Claims Processing and Management Services for Montana's Program for Automating and Transforming Healthcare (MPATH)

RESPONSE TO DPHHS-RFP-2020-0254T

February 18, 2020
2:00 p.m., Mountain Time



Section 3.10.10 – Edits, Processing, and Adjustments
Section 3.10.11 – Pricing and Payment
Section 3.10.12 – Benefit and Reference Data Management
Section 3.10.13 – Claims Data and Reporting
Section 3.10.14 – System Administration and Operations
Section 3.10.15 – Service Authorizations

Submitted electronically to:

Tia Snyder
Procurement Officer
Phone: (406) 444-3315
Fax: (406) 444-2529
E-mail: tsnyder@mt.gov

Submitted by:

CNSI
2277 Research Blvd.
Rockville, MD 20850
(301) 634-4600

Table of Contents

3.10.10 Edits, Processing, and Adjustments 633
3.10.11 Pricing and Payment 730
3.10.12 Benefit & Reference Data Management 800
3.10.13 Claims Data and Reporting 845
3.10.14 System Administration and Operations 883
3.10.15 Service Authorizations 943

3.10.10 Edits, Processing, and Adjustments

This section addresses claims editing, processing, and adjustment requirements. The solution will adjudicate all claims transactions and apply edits based on configurable business rules (e.g., duplicate, history, bundling, procedure, service limit(s), accumulators such as dollar and units limits reached monthly, annual, and lifetime, diagnosis codes, procedure code relationships, service authorizations, age, gender, eligibility, provider type, specialty, and category of service, and NCCI editing). The solution will have configurable claim transaction adjustment processes with automated and ad-hoc functions to support retroactive rate changes, procedure or diagnosis code revisions, benefit plan updates, and audit activities. The Offeror must describe in detail their approach to meet each of the Edits, Processing, and Adjustments requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Team CNSI's evoBrix X Core Claims module proposed as part of Claims Processing and Management Services (CPMS) provides comprehensive tracking through the entire claim life cycle — all the way from receipt of a claim through claims adjudication processing, resolution, adjustment and final remittance advice reporting. Each claim received by the CPMS solution through the paper claim process, HIPAA EDI transactions, and DDE, has a unique set of edits that are applicable to each claim type methodology. All of the background and screen edits in the solution are subject to the policies and business rules of DPHHS, and Team CNSI staff will configure them to meet the solicitation requirements. The evoBrix X CPMS solution adjudication process applies edit and audit rules for all modules within the system. This includes reference, member enrollment and eligibility, benefit plan coverage, provider eligibility, necessity of prior authorization, and evaluation of the claim header and detail information for accuracy and applicability. Figure 3.10.10-1 illustrates the life cycle of a claim as it adjudicates through the series of edits defined in rules engine, RuleIT.

The Team CNSI Advantage

Team CNSI's evoBrix X Software-as-a-Service solution is the first fully modular Medicaid solution that aligns with the MITA standards and modularity requirements of CMS.

- evoBrix X Core Claims module includes over 1,700 comprehensive, pre-built Medicaid rules which are easily configured
- Team CNSI has over 50 years of combined experience in supporting claims processing
- The claims edit parameters like CARC, RARC, and Default Disposition are easily configurable using application screens

MTCPM-1.2.4-252

During the claim adjudication process, edit rules are executed in sequence before a final decision is made on the claim. Some of the key edits that a claim goes through during the adjudication process are:

- Reference
- Member
- Enrollment
- Benefit plan
- Provider
- Service authorization
- Other – Validation, Pricing. Limit, Conflict, Duplicate and CCI

All edits are pre-configured and maintained in Team CNSI's RuleIT rules engine. RuleIT is one of core aspects of our solution that enables Team CNSI to offer a configuration-driven approach. RuleIT acts as a centralized business rules repository and will empowers Team CNSI's business operations authorized users to maintain the business rules. RuleIT contains built-in business vocabularies tied to Medicaid claims processing environments which facilitate quick implementation. Employing a run-time caching mechanism for improved performance, RuleIT contains rules that are logical statements consisting of

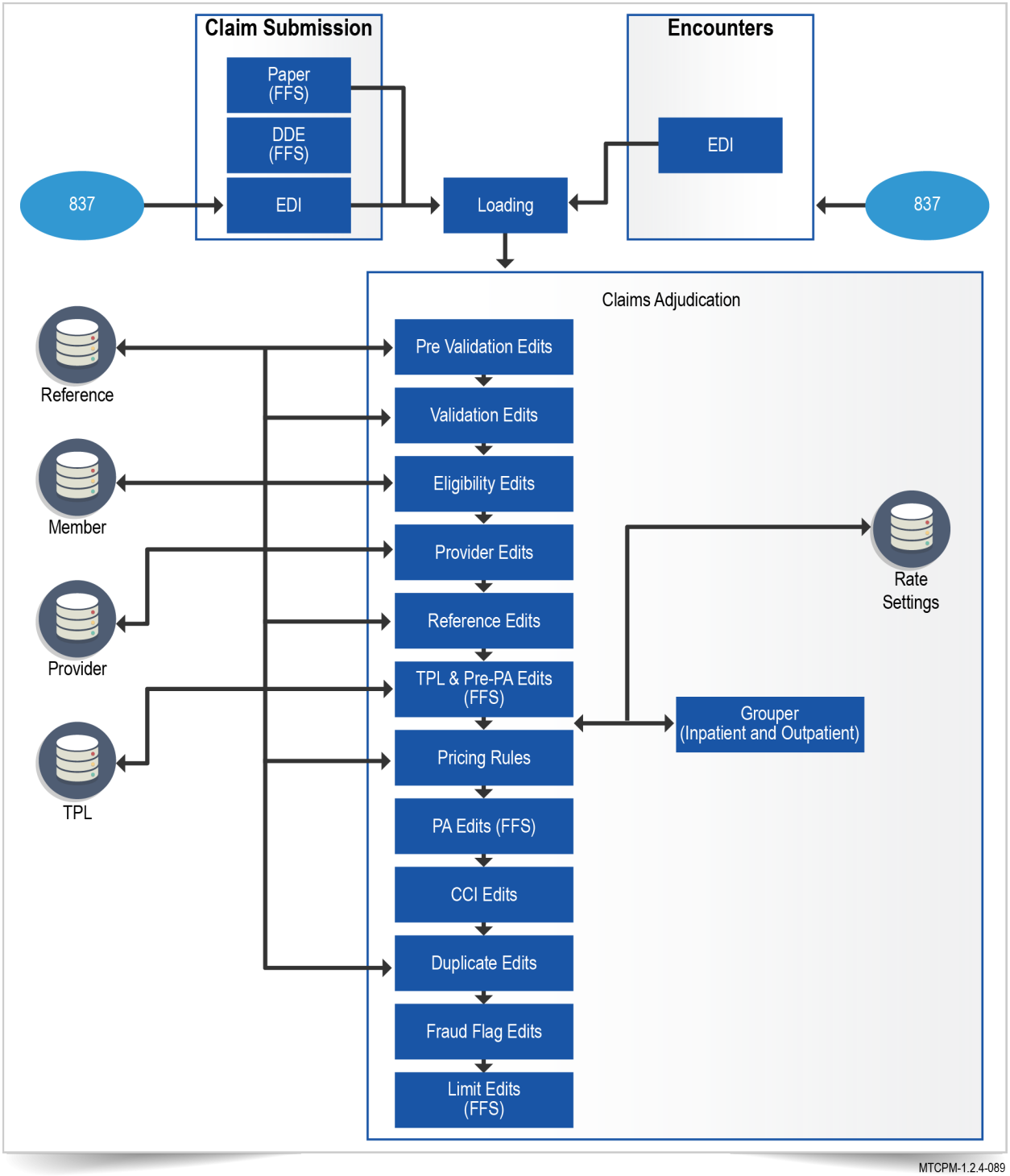


Figure 3.10.10-1. Claims Flow and Edit Rules Sequencing. Team CNSI's evoBrix X Core Claims module provides a proven adjudication engine for processing of claims and encounters.

conditions. The RuleIT Composer provides the ability to create, edit, and maintain business rules in English-like language that are then rendered by the RuleIT Processor (the run-time engine). Edits are one of the types of rules implemented in RuleIT. This feature gives the user the ability to understand, interpret, modify, or create new rules for claims adjudication. Figure 3.10.10-2 illustrates a sample edit created using RuleIT.

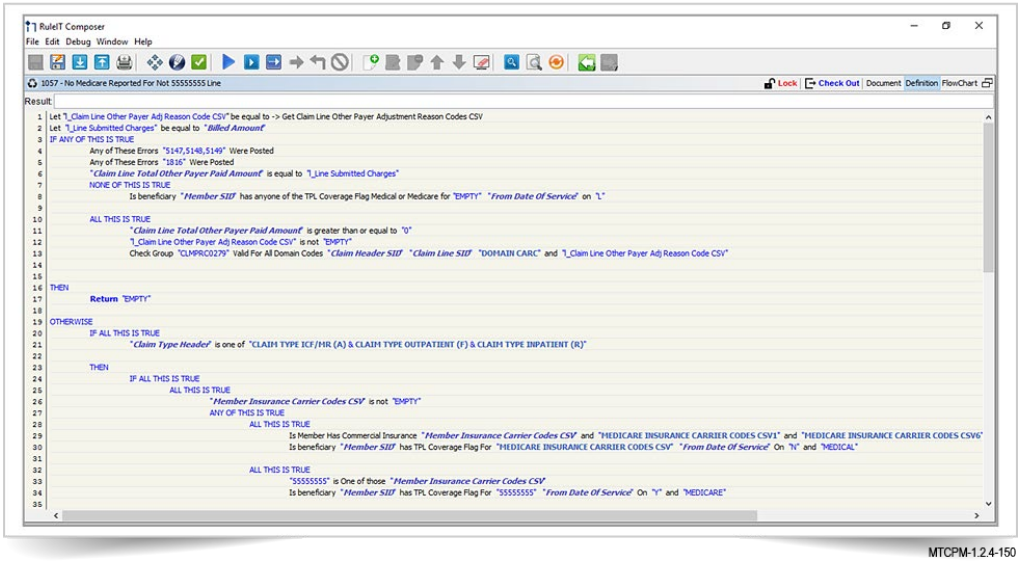


Figure 3.10.10-2. Sample RuleIT Screen for a Business Rule. RuleIT screens provide a user-friendly way to create and review business rules so that rules can be quickly created and tested when changes occur.

Out of the box, evoBrix RuleIT engine contains a set of rules readily available for claims adjudication and a business dictionary that can be configured to specific policies of DPHHS. evoBrix RuleIT engine provides ability to configure new edits without changing the underlying application code. This capability facilitates the quick implementation of new regulatory changes in evoBrix X CPMs solution without the inherent difficulties of translating business requirements into code. This function allows for clear impact analysis review, robust and repeatable testing, and error-free implementation of new edits without writing complex application code.

Configurable data tables are used in conjunction with the rules engine to maximize flexibility within the evoBrix X Core Claims solution. The data tables are part of the core claims module database. evoBrix X provides screens and tools that allow authorized users to add and modify data sets. The table-driven architecture helps making changes to the functionality without modifying the code.

When a claim does not fully meet all of the rules and validations that are ran against it, the claim gets an error code assigned to it. This error code, again, is highly configurable through the evoBrix X solution online screens. Each error code has standard Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) attached to it that will provide valuable information to the provider as to the final resolution of the claim. Properties attached to an error code include "Error Type," which determines whether the edit is fatal or can be overridden as a warning. Other configurable parameters related to an error code include the "Forcible" indicator, that allows the edit to be overridden by a Claims Resolver, error disposition, begin dates, and end dates. Begin and end dates are used to turn edits on and off and control when they are applied to claims. This enables the claims adjudication process to use the DPHHS policies applicable for the date or service or discharge and supports easy transition when policies change. evoBrix X also provides the ability to associate a standard HIPAA Adjustment Reason Code and Remittance Remark Code to each edit, so that these are correctly displayed on the X12 835 transaction.

EPA01

The Contractor's solution shall receive, store with encryption, maintain, and index all imaged documents. Imaged documents shall be indexed with sufficient metadata to allow users to search and retrieve images and easily differentiate between similar documents.

Team CNSI's evoBrix X Core Claims solution comes with an integrated document management solution that indexes and archives all the documents received either through online submission, mail or fax. The index metadata is configured in the document management solution based on the various applicable document types. Some of the index parameters include but not limited to Claim TCN, Date of Service, Provider NPI, Member ID, Prior Authorization Number etc. The indexed documents enable quick retrieval and also differentiate among similar documents.

EPA02

The Contractor's shall provide the ability to automatically suspend claims based on configurable business rules (e.g., inactive eligibility, one day-specific eligibility, nursing home span, attachment) including the ability to cycle claims for adjudication automatically when criteria is met as defined by the Agency

Claims adjudication is a core component of any Medicaid solution, and Team CNSI's evoBrix X Core Claims solution provides a comprehensive claims administration framework that maximizes automation based on configurable business rules.

At the core of the adjudication process is evoBrix RuleIT engine, Team CNSI's rules engine, which contains rules for editing and pricing that are required to appropriately adjudicate a claim. Our claims adjudication process applies edit and audit rules for all modules within the system. During this process, edit rules are executed in sequence before a final decision is made on the claim. Figure 3.10.10-3 provides a sample representation of the edit categories supported by the evoBrix X CPMS. The evoBrix X CPMS includes over pre-configured edits across the categories below.

Edit Category	Description
Pre-Validation	■ Edit 1008 - Unable to Assign Claim Type ■ If claim type is not derived during adjudication, system will post this edit at header level.
Validation	■ Edit 1000 - Header Service From Date Invalid ■ If statement From date is missing/Invalid in a claim, then post edit 1000 at header level.
Eligibility	■ Edit 1097 - Submitted DOB Does Not Match Eligibility ■ If submitted DOB is not matching with eligible member's DOB, then post edit 1097 at header level.
Provider	■ Edit 1130 - Submitter Not Active on Claim DOS ■ If a submitting provider is not active on a claim submission date, then post edit at header level.
Reference	■ Edit 1140 - Dental Tooth Number or Letter Missing or Invalid ■ If a dental claim is submitted with a procedure code which has Tooth Number Required Indicator as 'Y' and the tooth number is missing in that claim, then post edit 1140 at line.
Third Party Liability	■ Edit 1278 - Beneficiary has Other Insurance. ■ When a Beneficiary is eligible for other insurance to be paid prior to the payment from current payer, then post edit at header.

Edit Category	Description
Pricing Edits	■ Edit 1774 - Procedure Not Eligible for Bilateral Pricing ■ If the submitted procedure code is not eligible for bilateral pricing and the claim submitted with Bilateral modifiers, then post edit at line.
Prior Authorization	■ Edit 1121 - Claim DOS Not Within PA DOS ■ If PA submitted in a claim is not active on claim DOS, then post edit at header.
CCI	■ Edit 1187 - Mutually Exclusive Modifier Never Allowed - Daily. ■ Procedure codes with mutually exclusive modifiers are unlikely to be performed on a patient on a same day. When a claim is submitted with such codes, edit 1187 posted at line level.
Duplicate	■ Edit 1225 - Exact Duplicate of a Paid Claim in System History ■ When a submitted claim has exact values of a paid claim in history, then post edit at line.
Limit	■ Edit 1288 - Paid Amount has been Reduced Because of Another Paid Claim ■ For instance, A procedure of 10 units is allowed to perform on a member in a year and 6 units are already paid by history claims. In such case, if a new claim is submitted with 5 units of the same procedure, then 4 units out of 10 allowed units are paid and remaining 1 unit is mentioned as cutback. Edit 1288 is posted at line level.

Figure 3.10.10-3. Claims Edit Categories. The evoBrix X Core Claims Solution edits are configurable to enable the system to readily support changing business rules.

The solution has configurable disposition processing. The system has the capability to define a default disposition of accept, deny, suspend, ignore, and pay and report. It also has the ability to define a specific disposition defined by source of data (e.g., DDE, paper, encounters, system-generated) and claim type (e.g., nursing facility, inpatient, outpatient). This provides flexibility for progressive stringent enforcement of business rules.

Team CNSI's solution adjudicates 100% of the claims, and suspends claims based on policy configurations. Edits disposition controls how an edit will be handled by the system during claims adjudication when determining the claim status. Error code disposition can be configured based on the claim category (e.g., DDE, paper, system generated, replacement) and claim type (e.g., Inpatient, Outpatient, Nursing Facility). The evoBrix X Core Claims module allows each edit to be associated with a specific disposition, and if DPHHS choose to configure a business rule edit disposition to suspend, then the module automatically suspends claims based on configured business rules, and the claims staff would manually resolve all outstanding exceptions. Once criteria are met as defined by DPHHS, the evoBrix X Core Claims module's 'Release All' feature, as shown in Figure 3.10.10-4, helps to automatically re-processes all the released claims from the suspend queue.

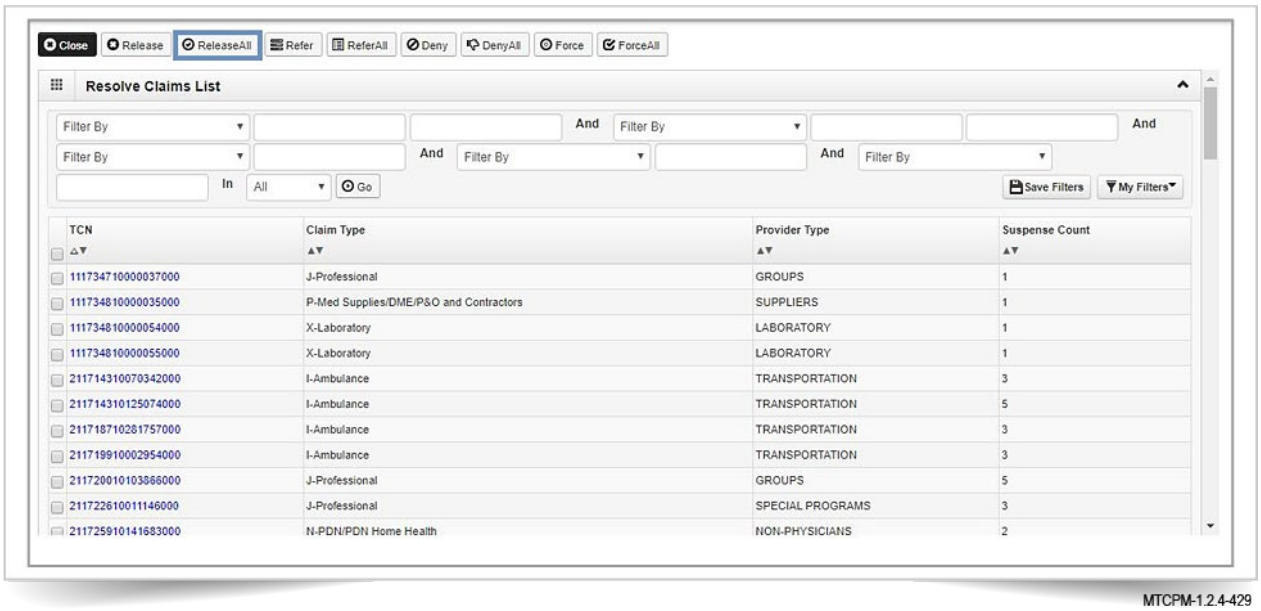


Figure 3.10.10-4. Claims Release All Capability. Our evoBrix X Core Claims module release all feature automatically re-processes all the released claims from the suspend queue.

Claims may be suspended for several reasons - essentially as a result of an inactive eligibility, one day-specific eligibility, nursing home span, attachment and failing one or more edits. In our solution, suspension actions result with the assignment of a set of header- and/or line-level exception codes. Following suspension, manual intervention is required as shown in Figure 3.10.10-5.

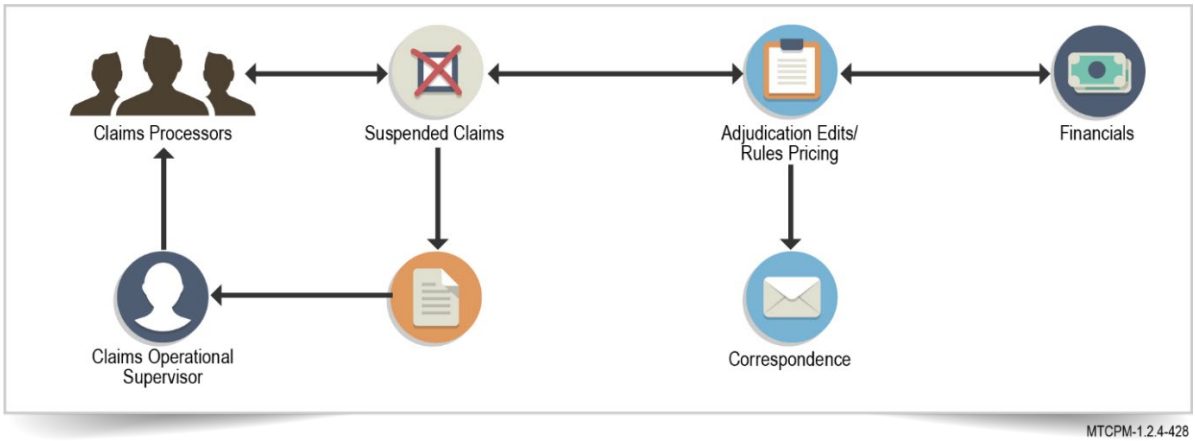


Figure 3.10.10-5. Post-suspension Claims Workflow. Suspended claims require action by claims staff to finalize adjudication.

EPA03

The Contractor's solution shall have the ability to receive service authorizations for services to be performed by specific and non-specific providers.

Team CNSI's solution does have the ability to receive service authorizations for services to be performed by specific and non-specific providers as long as provider is active and the record existing in evoBrix X CPMS. Specific and non-specific providers are able to submit a HIPAA 278 compliant authorization request via direct data entry screen for health care authorizations. The received service authorization is stored in evoBrix X CPMS. Each service authorization undergoes status changes based upon the decisions

made through workflow processes. Figure 3.10.10-6 shows information on the PA's stored in the solution.

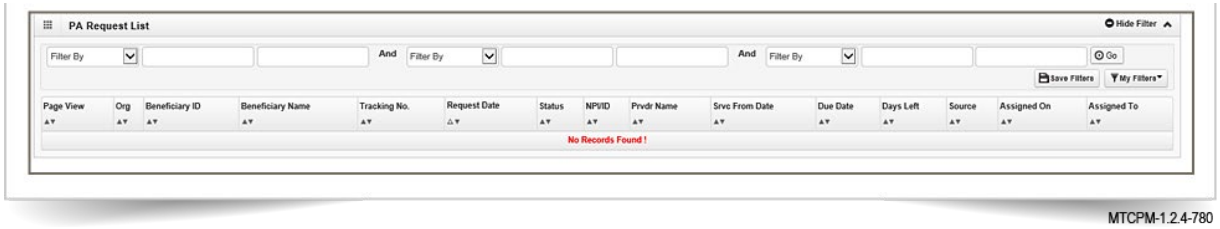


Figure 3.10.10-6. Service Authorization for Services to be Performed. Team CNSI's solution provides users the ability to view and manage service authorizations online.

EPA04

The Contractor shall adhere to data retention requirements cited in 45 CFR 164.316 and State specific policies. The Agency may require a longer retention period on an exception basis to support ongoing business needs (e.g., TPL recovery and drug rebate).

Team CNSI solution supports data retention requirements cited in 45 CFR 164.316 and State specific policies. Our solution will be configured for a longer retention period on an exception basis to support agency specific business needs. Policies and procedures and documentation requirements will be configured to agency specific longer retention period to support agency specific business needs. Our solution team will work with agency on the policies and procedures and documentation requirements and retention period to support the ongoing business needs.

EPA05

The Contractor's solution shall adjudicate all claims transactions and apply edits based on configurable business rules (e.g., Duplicate Checking Edits, History Checking Edits, Bundling Edits, Payment Error Rate Measurements (PERM) Audit Support, Edits based on trend analysis against claims history, NCCI / MUE – Medically Unlikely Edits, NCCI / PTP – Procedure to Procedure Edits, Edits for CPT4 to HCPCS Relationship, Maximum allowable units by Revenue Code/HCPCS relationship, Limit checks for client accumulators such as dollar and units limits reached monthly, annual, and lifetime, diagnosis codes to procedure code relationships, service authorizations, age, gender, eligibility, provider type/specialty, category of service) as defined by the Agency.

Team CNSI's solution provides real-time claims adjudication capability. At the core of the adjudication process is our evoBrix RuleIT engine, which processes edits that are required to appropriately adjudicate a claim. The other evoBrix X modules provides the necessary data to support the adjudication process. The solution provides comprehensive tracking throughout the entire claim life cycle – all the way from receipt of a claim through adjudication and final remittance advice reporting. The evoBrix X Core Claims module comes with a pre-built comprehensive set of edits configured in evoBrix RuleIT engine and provides the capability to modify or add based on DPHHS policies and business rules. The evoBrix X Core Claims module's adjudication process applies edit and audit rules, as shown in Figure 3.10.10-7. During the claim adjudication process, edit rules are executed in sequence before a final decision is made on the claim. Figure 3.10.10-8 also demonstrates how each category of Edits depends on the data contained in a particular set of data structure.

Edits are created and maintained in Team CNSI's evoBrix RuleIT engine, one of the core components of the evoBrix X solution that enables Team CNSI to offer a configuration-driven approach. evoBrix RuleIT engine acts as a centralized business rules repository and empowers Business users to maintain the business rules. RuleIT is packaged with pre-built healthcare dictionary vocabularies and edit rules that facilitates faster implementations. Employing a run-time caching mechanism for improved performance,

RuleIT contains rules that are logical statements consisting of conditions. The RuleIT Composer provides the ability to create, edit, and maintain business rules in English-like language and RuleIT Processor, the run-time engine is used during the claim adjudication. Edits are one of the types of rules implemented in RuleIT. This feature gives the user the ability to understand, interpret, modify, customize or create new rules for claims adjudication as per the agency specific business rules.

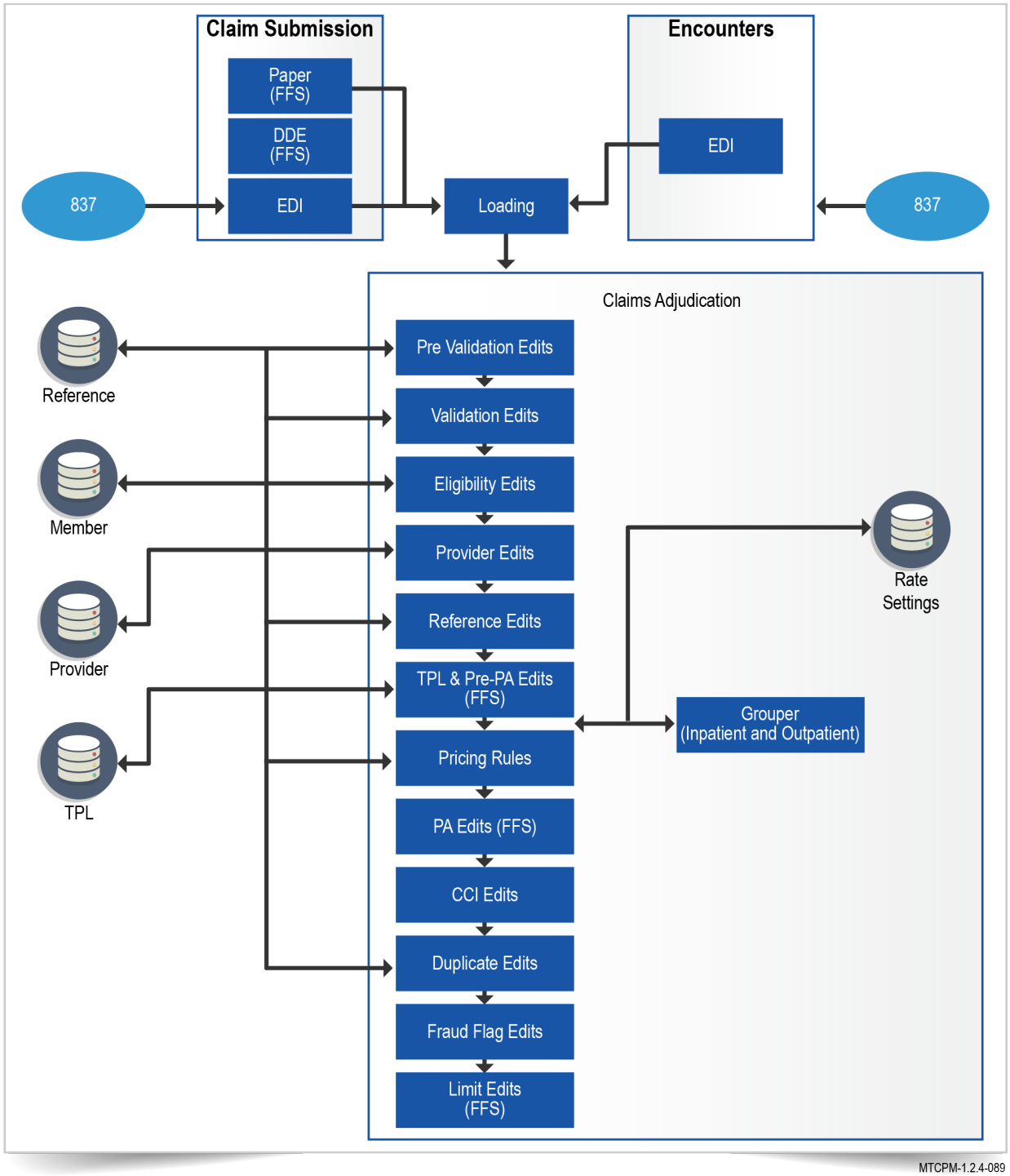


Figure 3.10.10-7. Claims Adjudication Sequence. Team CNSI's claims adjudication processing is the heart of our solution and support high-performance, rules-driven processing.

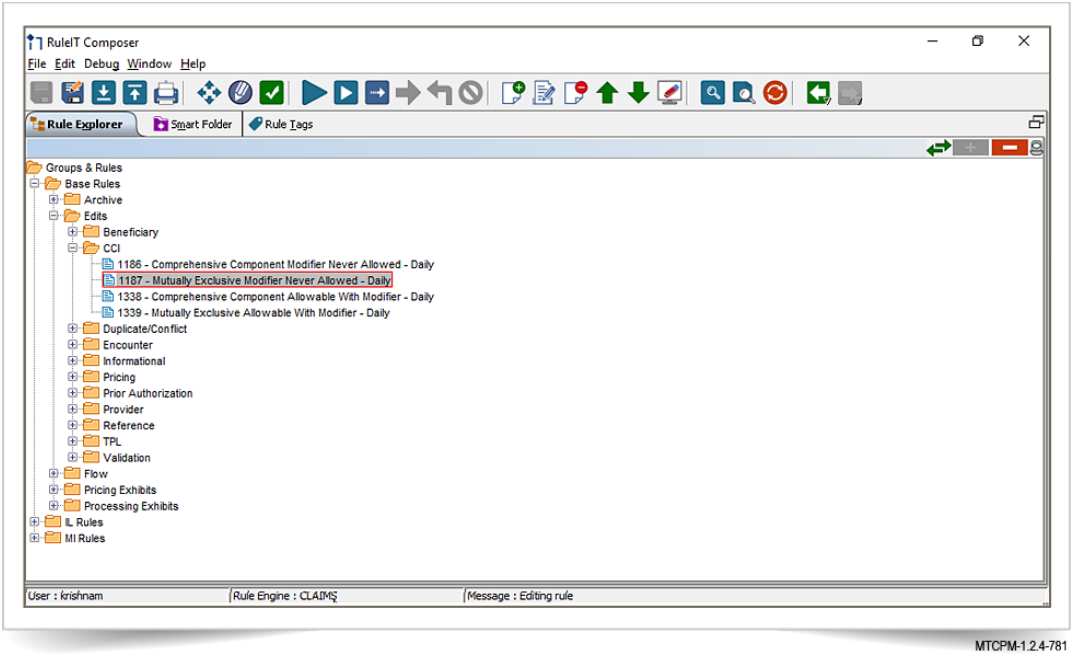


Figure 3.10.10-8. RuleIT Groups Hierarchy. RuleIT provides capability to organize rules by groups.

EPA06

The Contractor's solution shall process all claims transactions using edits and business rules during adjudication to validate transactions against service authorization(s), track utilization (e.g., authorized vs. used) and post edits if there are duplicate service authorizations or one or more service authorizations that conflict with each other as defined by the Agency.

Team CNSI's solution comes with a pre-built comprehensive set of edits configured in evoBrix RuleIT engine based on the rules defined by DPHHS. During adjudication, claim transactions are validated against service authorizations edits claims to ensure that claims do not exceed their benefit limit units or dollars. The evoBrix X Core Claims module comes pre-loaded with a rich set of service authorization related edits of the nature described in this requirement, one of which is shown in Figure 3.10.10-9.

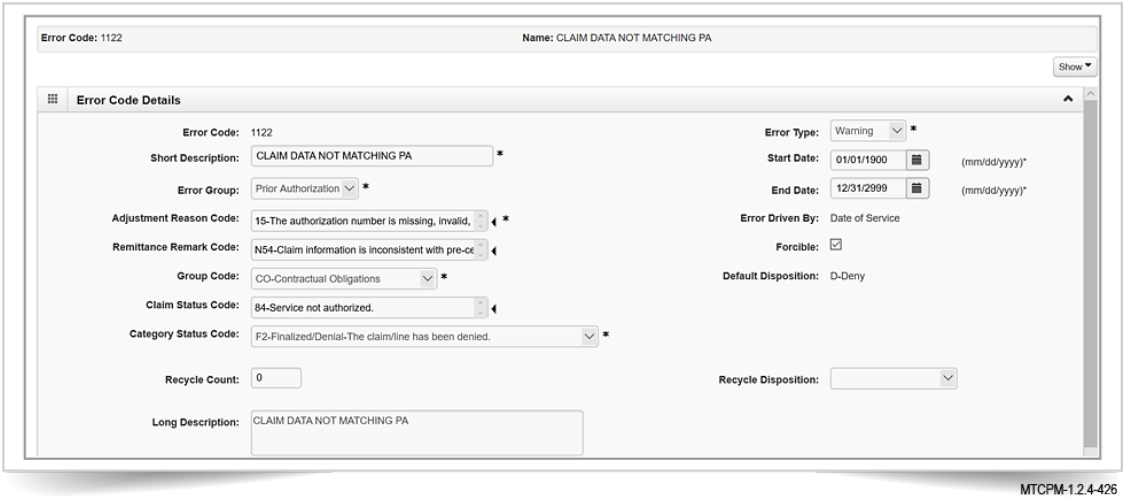


Figure 3.10.10-9. Configurable Error Codes for Service Authorizations Processing during Claims Adjudication. The evoBrix X Core Claims module is configurable to support service authorization edits.

The following provides examples of edits on claims transactions for service authorizations:

- Edit 1121 - Claim DOS Not Within PA DOS
  If PA submitted in a claim is not active on claim DOS, then post edit at header.
- Edit 1123 – PA Units or Dollar unavailable - If amount or units authorized for a PA are fully utilized and not available for current claim, post edit.
- Edit 1122 – Claim data does not match PA – If PA authorized units or authorized amount are fully utilized and not available for the current claim, as shown in Figure 3.10.10-10.
- Edit 1322 – PA Units cutback and paid - If units paid on a claim is greater than authorized units on PA, edit is posted and the difference of the two units is put in cutback.

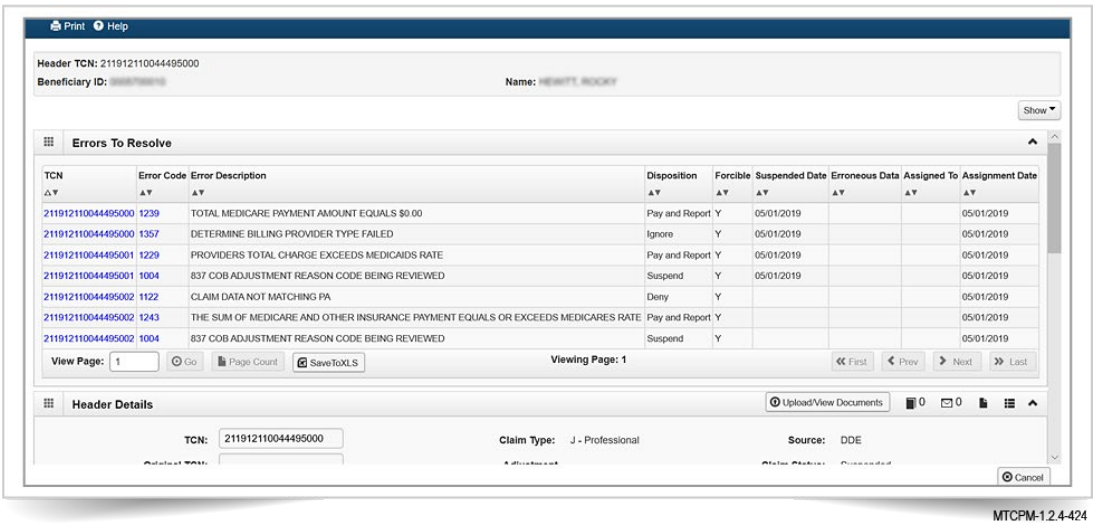


Figure 3.10.10-10. Claim Transaction with Edit 1122 – Claim Data Not Matching Prior Authorization. The evoBrix X Core Claims module provides an edit for handle service authorization units or authorized amount that are fully utilized and not available for the current claim.

When a claim transaction data passes all edits and is assigned a processing status of 'To be Paid', payable units and dollar values are updated in the database from the current claims for all the services having a PA during claim adjudication, as shown in Figure 3.10.10-11. During adjudication, if a claim transaction is either adjusted or voided, units and/or dollar amounts are restored in the database.

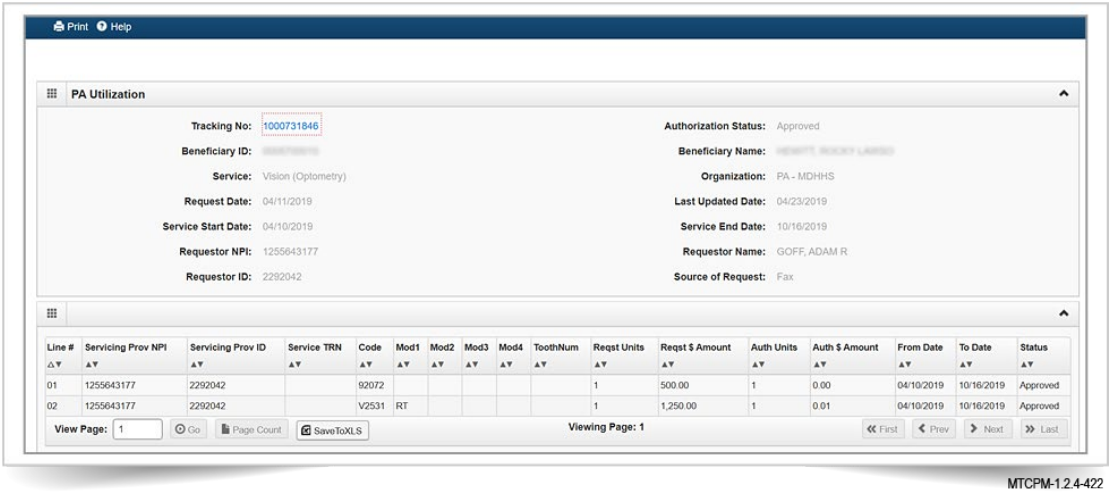
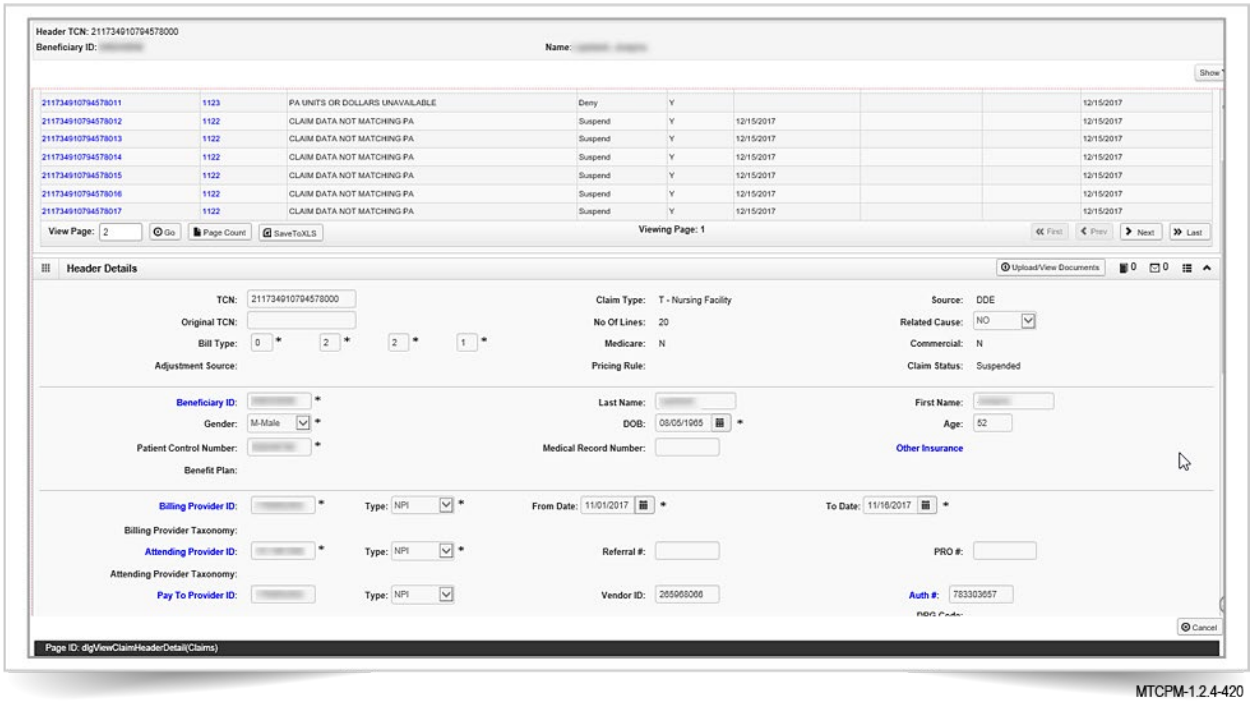


Figure 3.10.10-11. Service Authorizations approved for a unit and dollar amount. The evoBrix X Core Claims module tracks service authorization utilization.

EPA07

The Contractor's solution shall provide the ability to reprocess a claim transaction that has suspended due to a service authorization edit once the service authorization has been modified.

Team CNSI's solution supports the capability to re-process suspended claim transaction due to invalid service authorization and/or due to service authorization amount or units not available. Every suspended claim transaction has an edit set which provides a claim resolver with a reason for suspension. The evoBrix X CPMS comes with pre a pre-built such as Edit 1121 - Claim DOS Not Within PA DOS and Edit 1122 – Claim data does not match PA. If a claim transaction is submitted with an invalid service provider, claims will be suspended with Edit 1122. The claim resolver has the ability to review service authorization edits and determine the appropriate action to take on the suspended claim transaction. Once the claim transaction is resolved through the online screens, the solution makes it available to the adjudication queue for processing. In addition to being released through manual claim resolution, evoBrix X Core Claims module supports automatic recycling of suspended claims. Claims will pay once the service authorization has been corrected and claim is re-adjudicated.



MTCPM-1.2.4-420

Figure 3.10.10-12. Re-Processing of Suspended Claims. The evoBrix X Core Claims module provides full life cycle management of claims.

EPA08

The Contractor's solution shall have the ability to automatically reprocess claims (e.g., paid, denied, suspended) based on Agency configurable business rules (e.g., new/updated eligibility, TPL, benefit plan changes, aid category changes, rate updates, date of death, member liability, new/updated service authorization, edit resolution).

Team CNSI's solution identifies and reprocess claims and adjustments when reference data changes occur. These include reference data changes to rates, member eligibility, or policy updates. Agency staff has the ability to automatically reprocess multiple claims, to resolve suspended status, and then release all the claims at once through adjudication, using the "Release All" feature available to them on the screen.

The evoBrix X CPMS has automated processes to support business operations in performing mass adjustments. DPHHS's operations staff uses the mass adjustment screen to enter criteria to identify the claims that need to be adjusted, as shown in Figure 3.10.10-13. The system has a range of options within the criteria fields that is made available to the claims processor for mass adjustment.

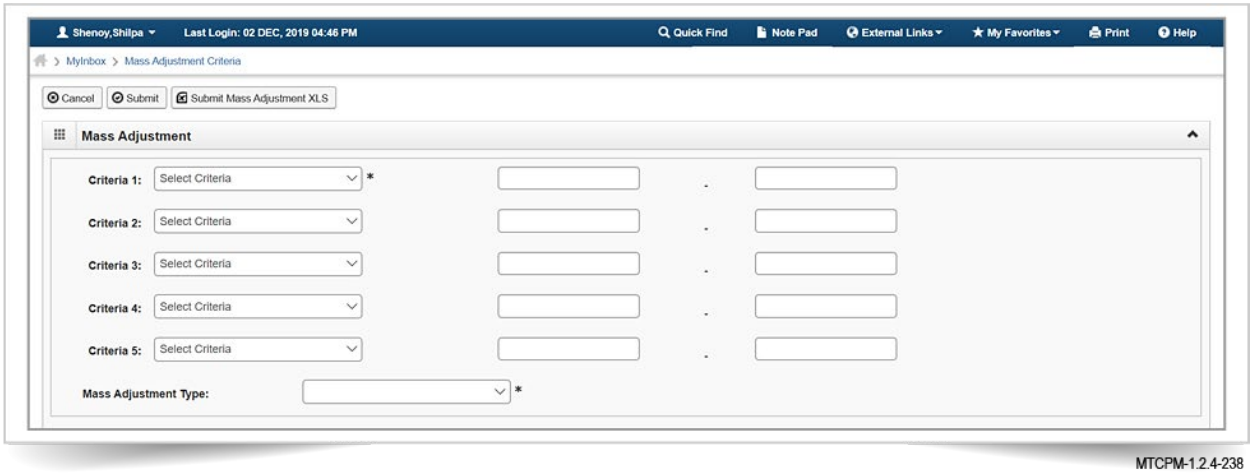


Figure 3.10.10-13. Mass Adjustments. The evoBrix X Core Claims module optimizes business processes with the ability to enter criteria to identify the claims that need to be adjusted.

Agency staff can enter up to five different selection criteria from the various available options before submitting the request. Specific claims can also be directly selected for the mass adjustment process by the Agency staff without having to enter the selection criteria. After the selection criteria is entered on the mass adjustment screen, the Agency staff can submit the request. The evoBrix X background processes keep polling the adjudication queue at regular intervals to look for claims for adjudication.

Agency staff, who submitted the mass adjustment request, reviews the adjusted claim's business status of pending, paid, or denied against the original claim. They compare the dollar amounts and other details, such as the benefit group number relevant to the claim, to ensure that the claim was processed as expected. When the results are in line with what was expected, the claims processor submits the mass adjustment batch to another claims processor for a second review. All of these activities are automated using the mass adjustment functionality within the evoBrix X Core Claims module.

EPA09

The Contractor's solution shall support electronic forms needed for proper claims processing and ensure the form is matched to the submitted claim.

Team CNSI's solution includes IBM Filenet as an integrated document management solution. Leveraging Filenet API's along with the use of an upload attachment functionality, as shown in Figure 3.10.10-14, authorized users have the ability to upload electronic forms using the web portal screens that are required for proper claims processing. The API leveraging index parameters will ensure to map documents to respective transactions and store them in the document repository.

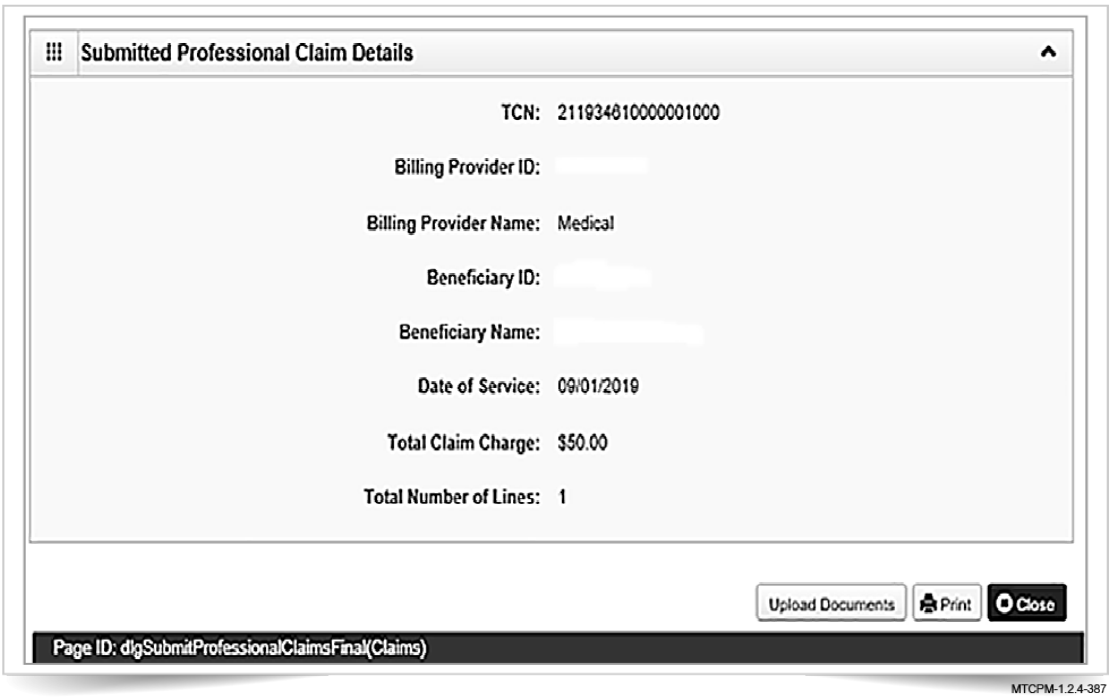


Figure 3.10.10-14. Uploading Documents to Support Claims. Our solution enables providers to upload documents to support the claims adjudication process.

Team CNSI has significantly shortened the response time to process the attachments received, for claims that are suspended in evoBrix X Core Claims. If the attachment is received, the claim is suspended for manual review of the attachment. If the attachment is not received within a pre-defined time, then the disposition of the claim is set to deny. Figure 3.10.10-15 shows all attachments received for a claim.

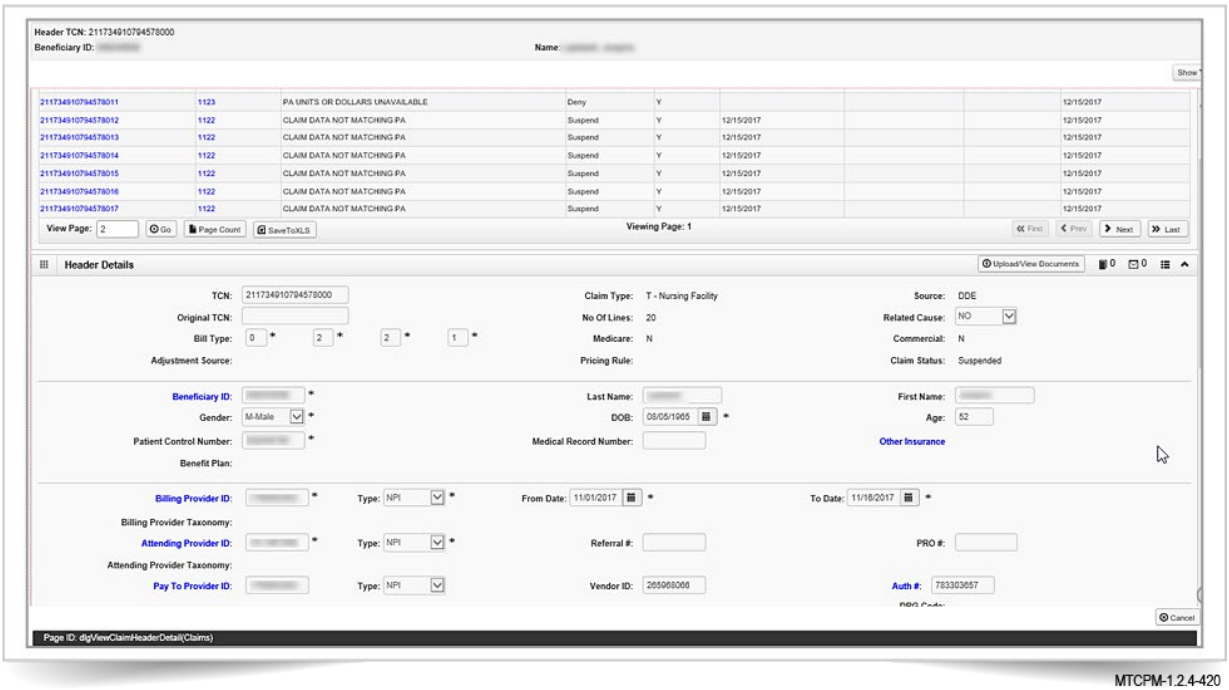


Figure 3.10.10-15. Claims Screen Linking Claim to an Attachment. Displaying the attachment along with claims data in the screens improves user friendliness and increases the productivity of operations and fiscal agent personnel in adjudicating a claim.

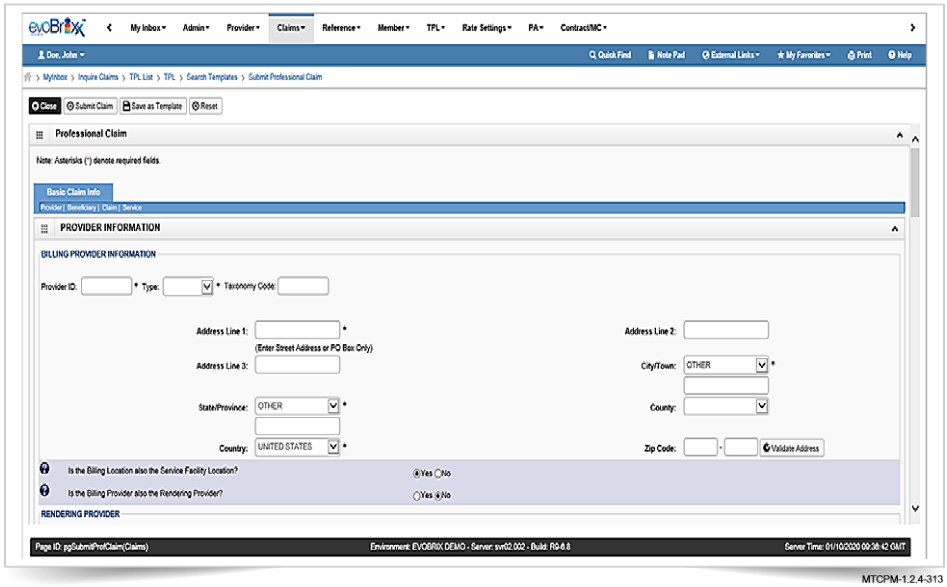
EPA10

The Contractor's solution shall include a validation feature that performs configurable real-time front-end editing prior to claim submission, prevent further processing for claims that fail the front-end edits (e.g., active provider enrollment, valid revenue codes, procedure codes, and diagnosis codes) as defined by the Agency.

Team CNSI's solution provides DDE intake process and a validation feature that performs configurable real-time front-end editing prior to claim submission. The evoBrix X Core Claims module offers easy to use screens for directly entering professional, dental and institutional claims data into the system. It offers those providers, who are authorized to do so, the ability to directly key in CMS-1500 Professional, UB04 Institutional, or ADA Dental claims from the portal into evoBrix X. The screens comply with HIPAA 5010 standards. The main features of the DDE Service include:

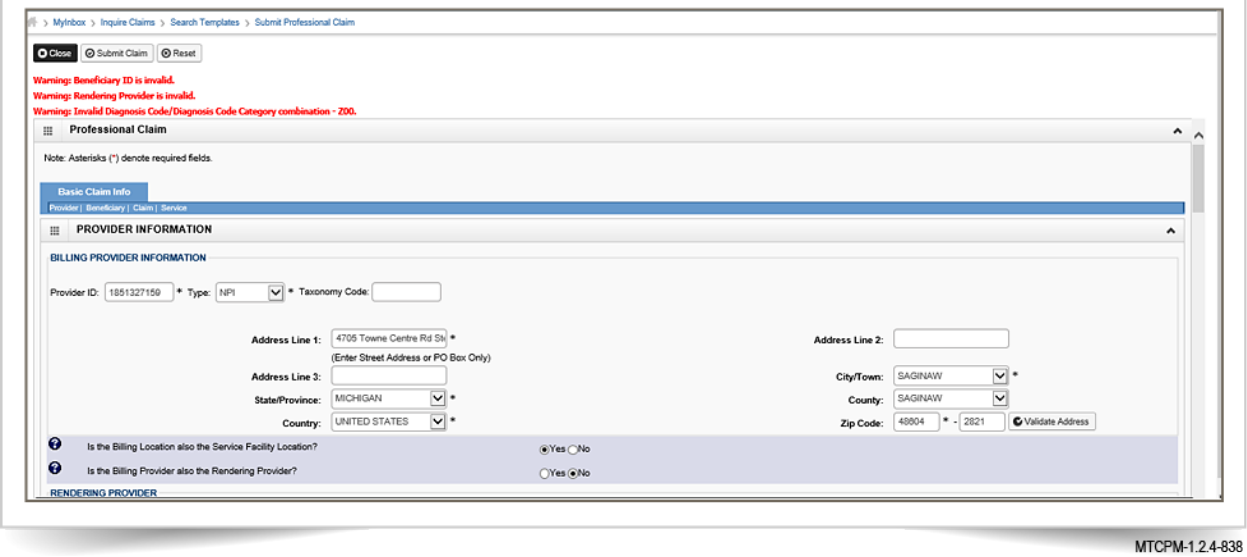
- The data captured using the web screens is validated for provider and member enrollment
- Validation of claims data as it is entered.
- Validation for data integrity with respect to the usage of Procedure codes, Revenue codes, Diagnosis codes and HCPCS Code
- On screen error messages when error conditions are encountered, thereby giving the user an opportunity to correct the data at the point of entry to prevent incorrect data from entering the system
- Ease of claims entry due to informative messages
- Reduction in claims suspension because of immediate data validation ensuring quality claims data entering the system.

A DDE claim submitted via the web portal, described in Figure 3.10.10-16 and Figure 3.10.10-17, is an alternate approach for claim submission to the evoBrix X Core Claims module. During this process, claims undergo a series of edits for issues such as format validation and missing information checks. A system generated unique TCN is assigned to the claim and adjudicated in real-time. Immediate acknowledgment and feedback to claims submitters is a key feature of the evoBrix X CPMS. The TCN is used to track and maintain a claim in the system. It contains information to identify the media of the claim (i.e., paper, EDI, DDE), invoice type information such as professional, dental and institutional, and the date it was received.



MTCPM-1.2.4-313

Figure 3.10.10-16. Submit Professional Claim. evoBrix X offers an easy-to-use screen for Professional Claim direct data entry. These screens enable providers with lower volume claims and Team CNSI personnel to expedite claim adjudication by entering the claim directly into evoBrix X.



MTCPM-1.2.4-838

Figure 3.10.10-17. Submit Professional Claim. evoBrix's X solution capture data using the web screens is validated for provider and beneficiary enrollment and validation for data integrity with respect to the usage of reference code sets.

EPA11

The Contractor's solution shall retain the relationship between the service authorization and any claim adjudicated against the service authorization, as defined by the Agency.

Team CNSI's solution provides the ability to authorize and issue service authorizations for service(s) to be provided for a member. When a service has been prior authorized the user defines either the maximum number of units or the maximum dollars to pay for these services over the service authorization time period. During the adjudication process, the service authorization data is reviewed to ensure that there are enough units/dollars remaining on the Prior Authorization to satisfy the current Claim.

During the service authorization editing in the claim adjudication, it is determined whether there are enough units/dollars available on the service authorization to pay the units/dollars of the current claim. If there is, adjudication continues and pay the claim. If there are no units/dollars available on the service authorization to pay anything on the current claim, the appropriate error is posted to the claim noting this fact. During claims processing, claims that require service authorization or referral are paid based on the parameters associated with the authorization record in the service authorization module. A claim for a service that requires a prior authorization and had none requested may be denied for payment or suspended and routed to a claims area for review. A claim submitted with an authorization in a "Denied" status is denied and not paid. Service authorization utilization is recorded against the respective PA record and the utilization information is viewable online as shown in Figure 3.10.10-18.

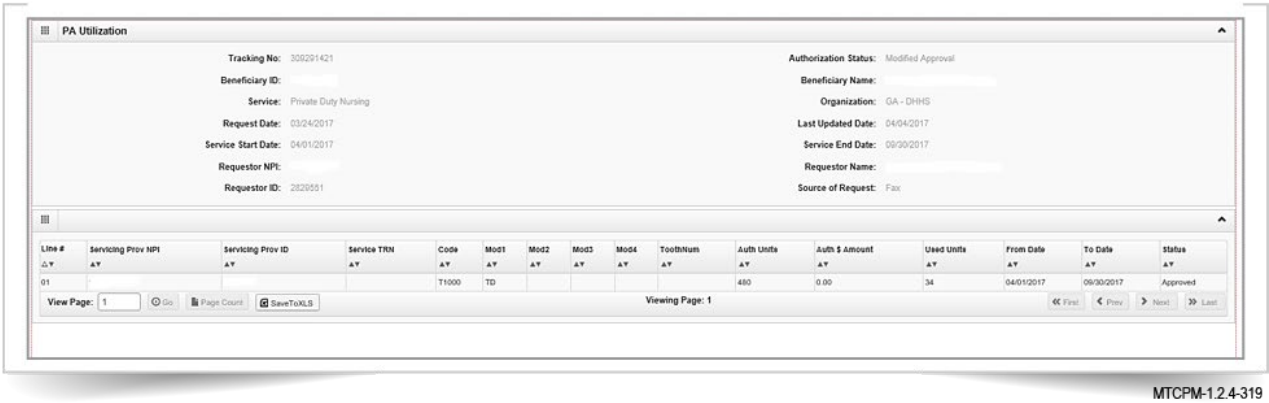


Figure 3.10.10-18. Service Authorization Utilization. The evoBrix X Core Claims module provides a complete service authorization utilization processing.

EPA12

The Contractor's solution shall capture, store, maintain, and display the status of each claims transaction (e.g., as suspended, paid, denied, to be paid, to be denied) based on Agency configurable business rules.

Team CNSI's solution provides a real-time Claim adjudication and captures the status of each claim transaction, as shown in Figure 3.10.10-19. At the core of the adjudication process is the RuleIT rules engine, which processes edits that are required to appropriately to adjudicate a claim. Adjudication process applies edit and audit rules for all modules within the system. During the claim adjudication process, edit rules are executed in sequence before a final decision is made on the claim. Disposition processing controls how an edit will be handled by the system during claims adjudication when determining the claim status (e.g., in process, suspended, paid, denied, void, Adjusted). Error code disposition can be configured based on the claim category (e.g., DDE, paper, system generated, replacement) and claim type. Claims may be suspended or denied for a number of reasons - essentially as a result of failing one or more edits, and thereby being assigned a set of Header-level and/or Line-level Exception codes. Additional status (e.g., to be paid, to be denied) can be configured in evoBrix X CPMS based on DPHHS business rules.

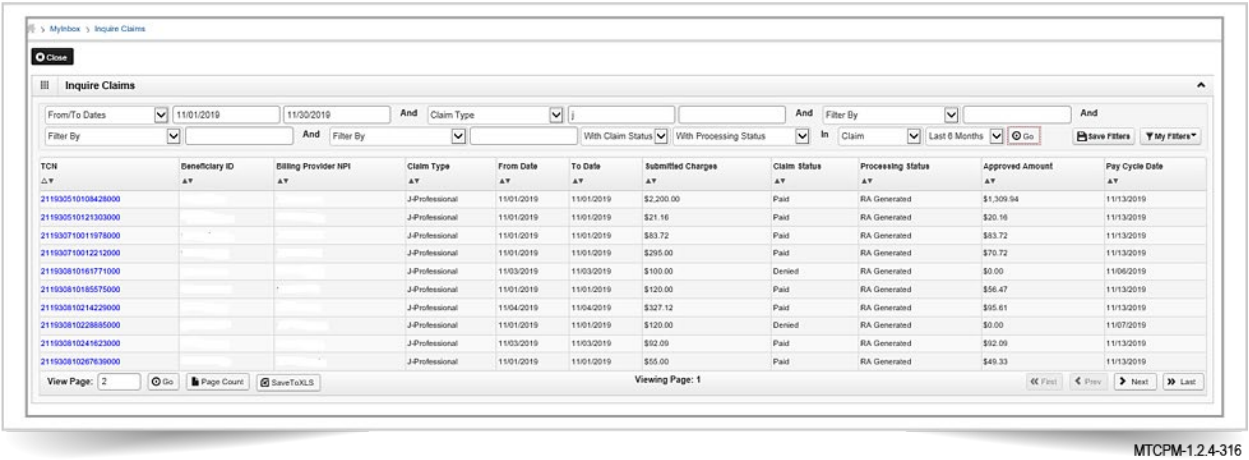


Figure 3.10.10-19. Claims Inquiry Screen with Claim Status. The evoBrix X Core Claims module captures and displays the status of each claim transaction.

EPA13

The Contractor's solution shall enforce timely filing requirements using configurable business rules as defined by the Agency.

Team CNSI's evoBrix X solution is pre-configured with timely filing validations. Our solution provides pre-configured timely filing limitation requirements that all provider-submitted claims are no later than twelve (12) months from the date of service and agency can easily configure the time period value from twelve (12) months to agency defined time value.

EPA14

The Contractor's solution shall provide the capability for Agency staff to mass adjust claims based on specific criteria and allow for edits to be bypassed as defined by Agency. At the direction of the Agency the Contractor's must perform the requested mass adjustment using the Agency's specific criteria.

Team CNSI's solution has a highly automated solution and mature business operations processes to perform mass adjustments. DPHHS staff uses the evoBrix X Core Claims module's mass adjustment screen to enter criteria to identify the claims that need to be adjusted. The system has a range of options within the criteria fields that is made available to the claims processor for mass adjustment.

DPHHS operation staff can enter different selection criteria, as shown in Figure 3.10.10-20, from the various available options before submitting the request. Specific claims can also be directly selected for the mass adjustment process by operations staff without having to enter the selection criteria. After the selection criteria is entered on the mass adjustment screen, operations staff can submit the request, as shown in Figure 3.10.10-21. The evoBrix X CPMS solution background processes conducts polling of the adjudication queue at regular intervals to submit claims for adjudication.

DPHHS business operations staff, who submitted the mass adjustment request, reviews the adjusted claim's business status of pending, paid, or denied against the original claim. They compare the dollar amounts and other details, such as the benefit group number relevant to the claim, to ensure that the claim was processed as expected. When the results are in line with what was expected, the claims processor submits the mass adjustment batch to another claims processor for a second review. All of these activities are automated using the mass adjustment functionality within the evoBrix X Core Claims module.

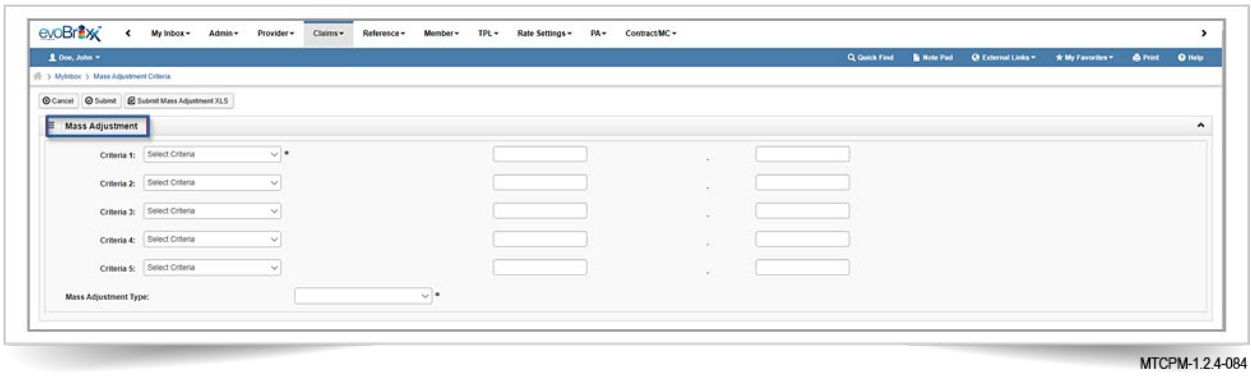


Figure 3.10.10-20. Mass Adjustment Criteria Selection. DPHHS staff use the evoBrix X mass adjustment screen to enter criteria to identify the claims that need to be adjusted.

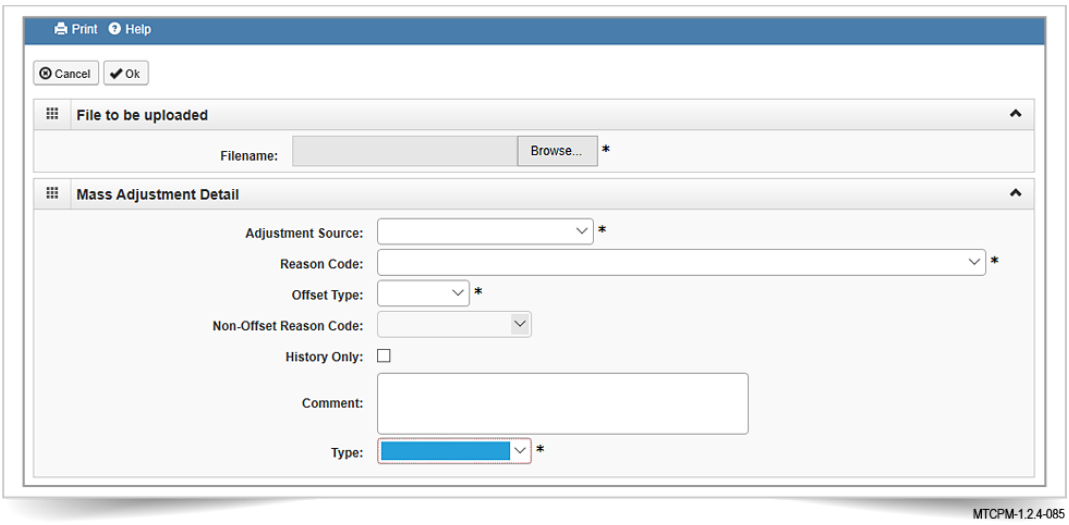


Figure 3.10.10-21. Mass Adjustment Submission. Mass adjustment capability saves DPHHS staff time in conducting changes across a large number of claims records.

EPA15

The Contractor's solution shall provide searchable options that are applicable to specific business rules including but not limited to: client, provider, benefits, reference data, claims processing, prior authorization, third party liability (TPL), and financial, as defined by Agency

Team CNSI's solution supports rules searches in RuleIT, CNSI's purposefully built for Medicaid programs, based on keywords such as client, provider, benefits, reference data, claims processing, prior authorization, third party liability (TPL), and financial. RuleIT provides a repository of a single reference library of all rules used for claims processing. A single reference library helps overcome eases the ongoing rules maintenance burden. Figure 3.10.10-22 provides an example of a search conducted using the keyword "1094."

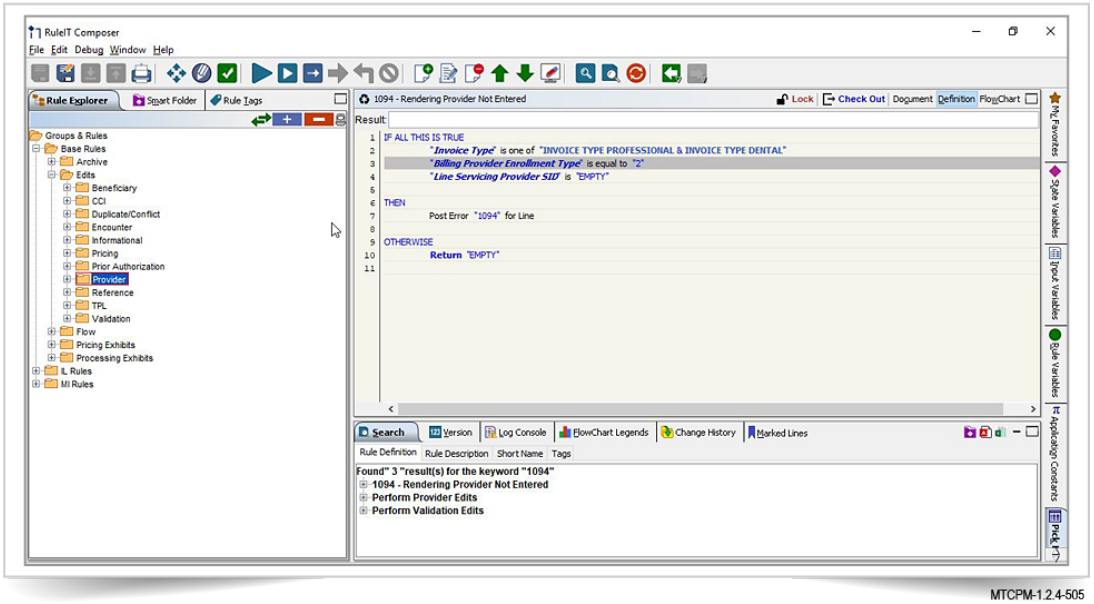


Figure 3.10.10-22. RuleIT Rules Searching. The evoBrix X Core Claims module supports a single repository for all rules and provides the capability to easily conduct rules searches.

RuleIT maintains complete visibility for each business rule, including:

- Rule author and created date
- Rule name and description
- Effective dates
- Complete change history
- Option to compare and track multiple versions of the rule

The evoBrix X CMPS also supports claim search using various keywords such as beneficiary ID, billing provider ID, service authorization number, and more as shown in Figure 3.10.10-23.

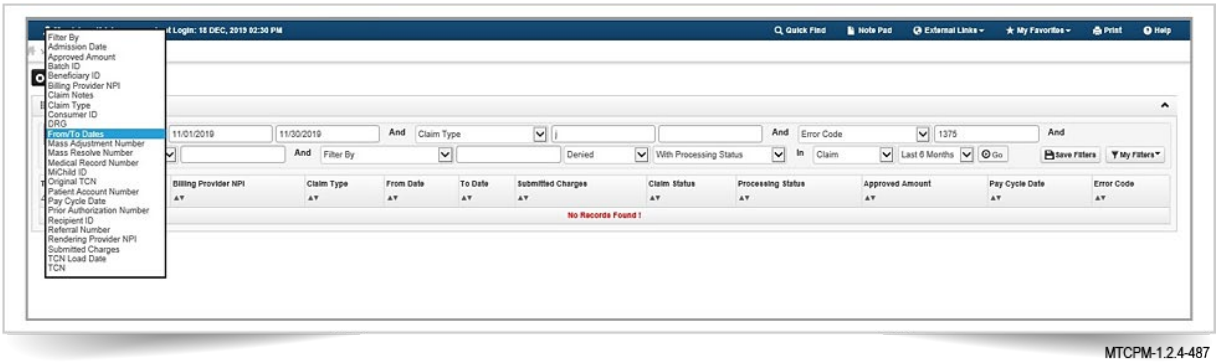


Figure 3.10.10-23. Claims Searching. evoBrix X CPMS supports a claim search using various keywords.

EPA16

The Contractor's solution shall optimize the processing steps for working suspended claims to maximize user efficiency and meet or exceed claim suspension service level agreements.

Team CNSI's solution has an integrated workflow engine to assign suspended claims automatically to specific workgroups in order to optimize the processing of suspended claims in a timely manner and to maximize user efficiency. Assignment of the workgroup is driven based on claim parameters such as invoice type, claim type, and the edit groups. The edit groups that suspend a claim for a valid business scenario can be configured in the workflow engine. The workflow engine will assign all such suspended claims to a special workgroup and will continue to monitor the action of the workgroup on the assigned claims to meet the claim suspension service level agreements and If no action or action has not been completed on a suspended claim within the timeframe defined by the DPHHS, the evoBrix X Core Claims module will automatically notify the supervising authorities to review the progress and take appropriate measures.

EPA17

The Contractor's solution shall accept attachments through the following mechanisms: fax, mail, electronic upload via the online provider portal. Additionally, the Contractor's solution shall accept attachments via standard HIPAA transaction formats or any standard healthcare delivery methods.

Team CNSI's solution accepts attachments via multiple modes, including online provider portal, fax, mail (paper) attachments and accept paper attachment indicator in the standard X12 HIPAA transaction formats.. In order for providers to mail or fax attachments, the submitter must generate a cover sheet using the user-friendly interface. The provider clicks "Print Coversheet" to generate a barcoded cover sheet to be printed and used as a leading page to submit the attachments. The unique bar code generated and displayed on this cover sheet automates the identification and association of attachments with claims. The following provides details regarding various mechanisms that are available for the submission of attachments:

Fax and Mail: Team CNSI evoBrix X solution performs the following steps during paper attachment intake:

1. All hard copy documents received in the mailroom are prepared for scanning.
2. High-speed scanners are used for producing images of hardcopy documents.
3. During imaging, a unique transaction control number (TCN) is assigned to each piece of correspondence and printed onto the physical document.
4. The scanned image is saved and uploaded into FileNet for retrieval, as needed.

The TCN identifier assigned to the document provides the means for retrieving that document and any related documentation. This allows us to process and report status on documents throughout the claims' life cycle. The TCN shows the actual business date of receipt, record type, batch number, and sequence number. Attachments receive the same unique identifier as the primary document to allow all related documents to be retrieved as a unit. Standard HIPAA transaction format: Team CNSI's proposed solution supports receiving and processing of supplemental document necessary to adjudicate a claim. CNSI can receive supplemental document via mail, fax and secure portal in conjunction with the paperwork attachment indicator that can be send in the 837 X12 HIPAA transaction. Our solution also supports attachment indicator on claims direct data entry (DDE) screens for online claims submissions that providers can use for indicating how they intend to submit supplemental document necessary to adjudicate a claim.

Electronic Upload: Team CNSI offers a streamlined upload process via the provider portal to load attachments. A provider has the option to upload an attachment when a claim is submitted using the Direct Data Entry (DDE) option as shown in Figure 3.10.10-24.

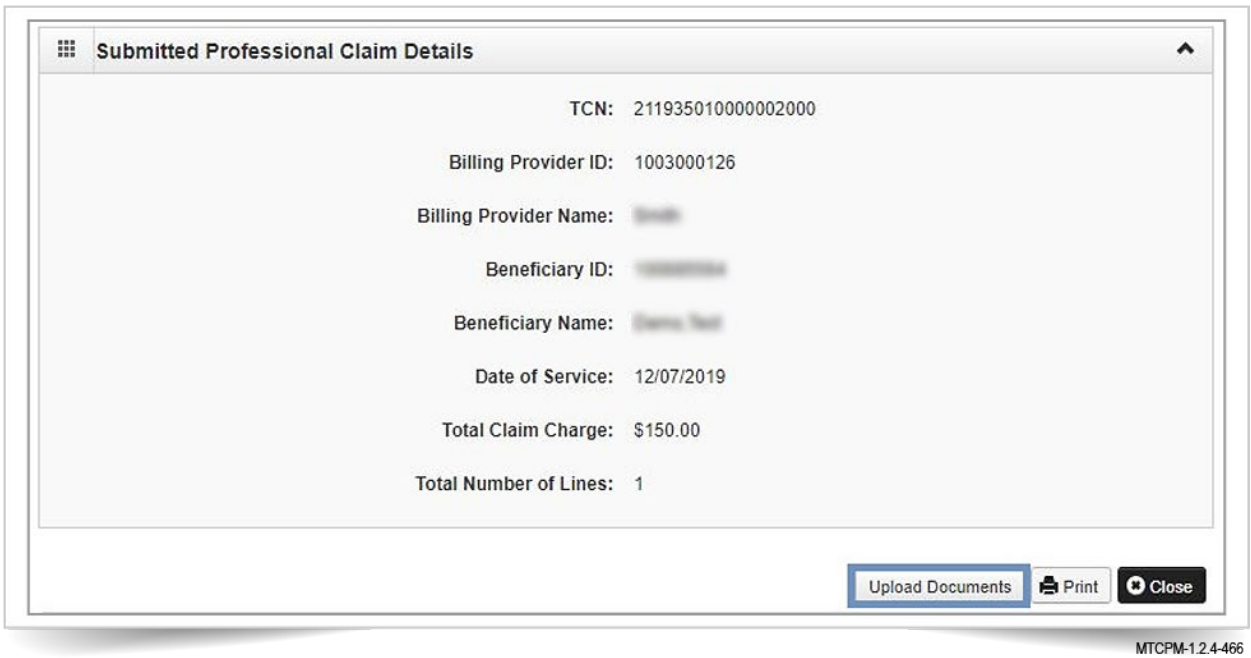


Figure 3.10.10-24. Uploading Documents to Support Claims. Our solution enables providers to upload documents to support the claims adjudication process.

Additionally, a provider can also upload documents from the Claims Detail page using the 'Upload/View Documents' button shown in the screenshot below. When a user clicks on that button, they are navigated to the Claims Document List where they can enter the document information, upload the document and print the required coversheet as seen in Figure 3.10.10-25 and Figure 3.10.10-26. Upon receipt, all attachments go through a validation process.

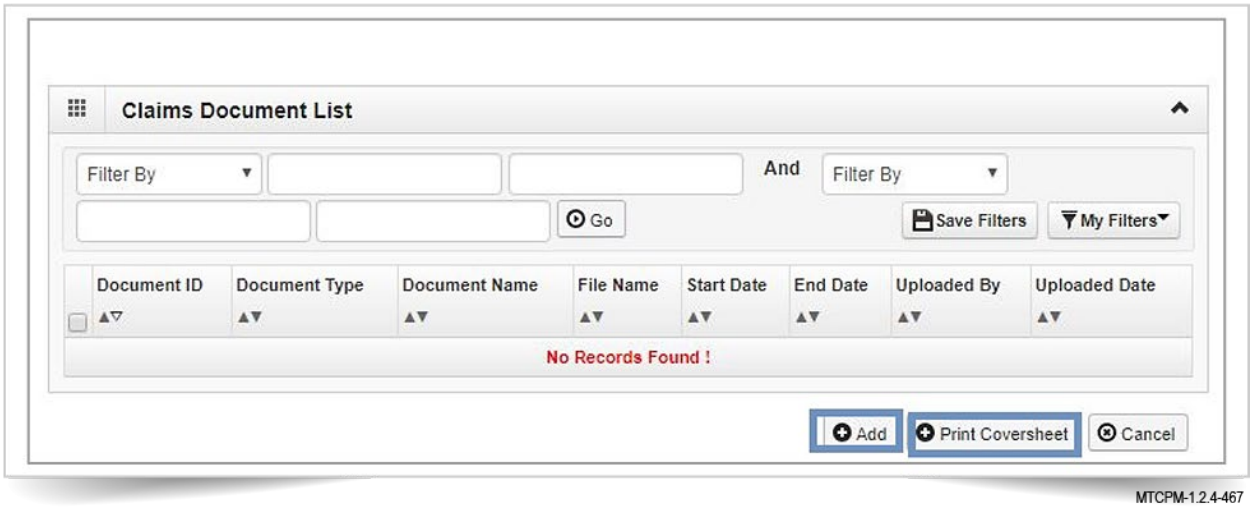
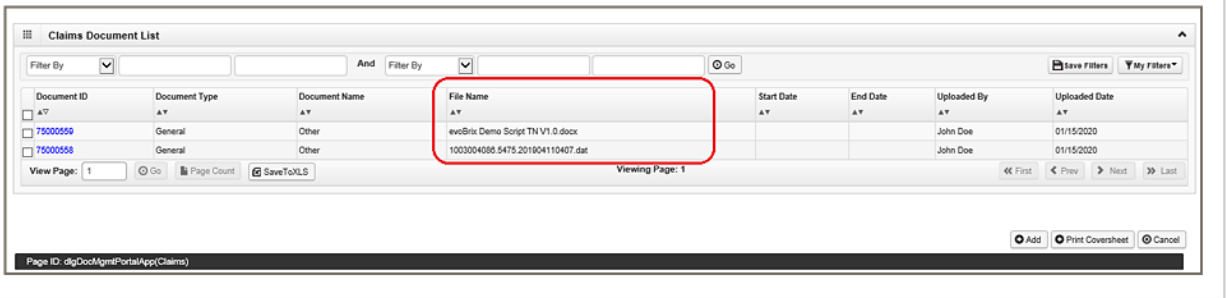


Figure 3.10.10-25. Displays list of Uploaded Documents from Claims Detail Page. The evoBrix X Core Claims module supports adding an attachment and printing a coversheet.



MTCPM-1.2.4-805

Figure 3.10.10-26. List of Uploaded Documents from Claims Document List. The evoBrix X Core Claims module supports adding an attachment and printing a coversheet.

EPA18

The Contractor's solution shall provide a base set of effective dated claims edits, audits, and rules for Agency use and maintain a version history of rules.

At the core of the adjudication process is RuleIT which contains rules for editing and pricing that are required to appropriately adjudicate a claim. RuleIT is pre-configured with a base set of edits, audit, and rules that enables Team CNSI to more rapidly implement the Core Claims module. The solution also supports history maintenance using effective date linkages. Based on the history records, the associations are maintained for auditing as shown in the Figure 3.10.10-27.

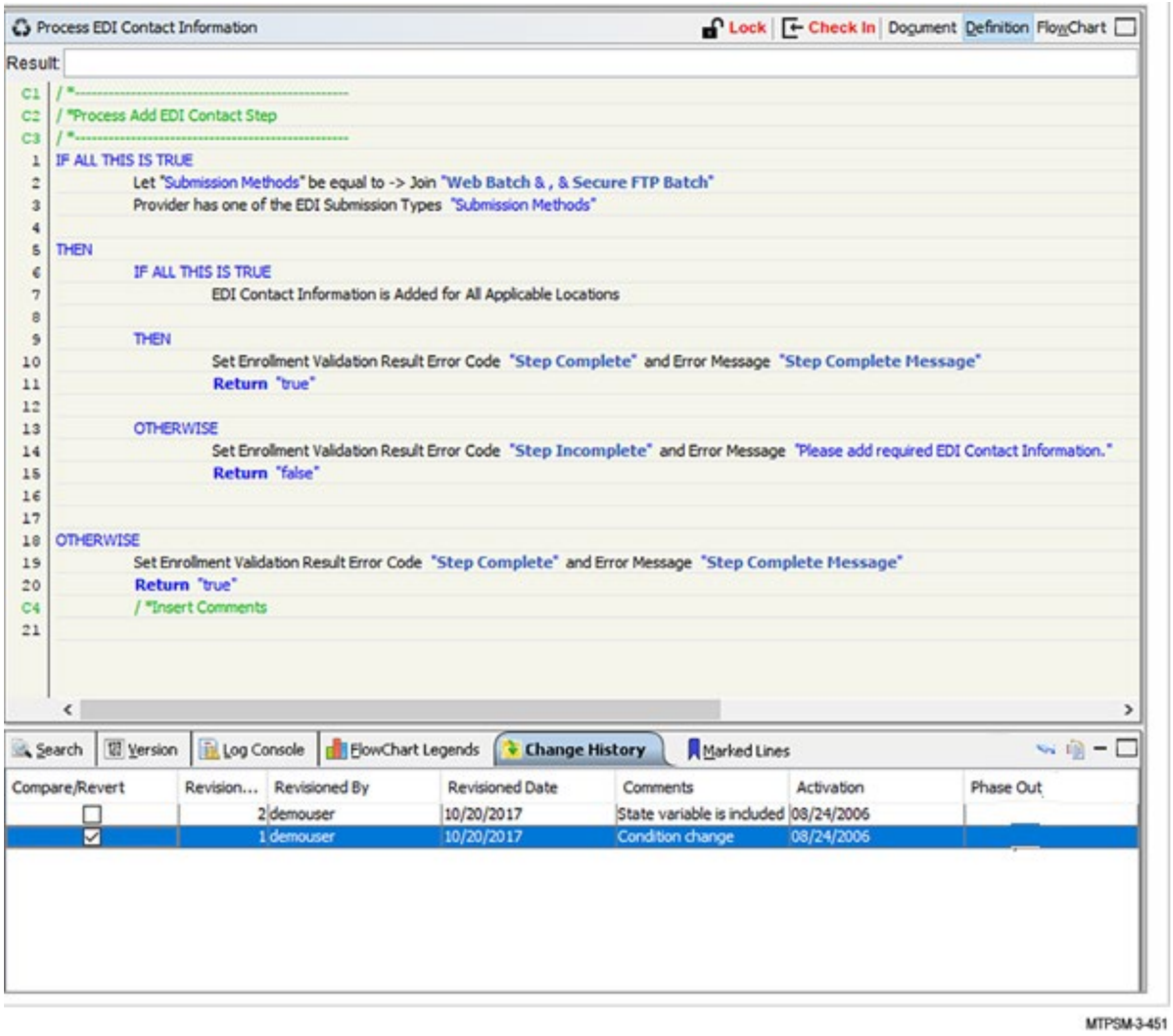


Figure 3.10.10-27. RuleIT Composer Change History Screen. RuleIT maintains an audit trail of the rule changes.

EPA19

The Contractor's solution shall create, store, and maintain configurable edits and audits (e.g., member groups, benefit plan, age, region, claim type, procedure, provider type and/or specialty, provider taxonomy, tooth number, modifiers, benefit plan or lock-in or lock-out) as defined by the Agency.

In addition to RuleIT, our evoBrix X Core Claims module's Reference data management services provides the capability for DPHHS to create, store and maintain configurable edits and audits. The module maintains variety of claims data sets which includes benefit plans, code sets (i.e., procedure, revenue, and surgical) and claim processing groups. DPHHS will have the capability to configure and maintain claim edits for each of these data sets. Examples of these edits are:

- Configure age ranges, gender, unit types, claim types and provider type/specialty (taxonomy) for the benefit plans and procedure codes
- Configure modifier for the procedure codes
- Configure claim processing groups which defines the claim editing rules for specific set of claims, provider types/specialty(taxonomy) and services, and modifiers

- The solution further provides the capability to configure member group and lock-in or lock-out as defined by DPHHS

EPA20

The Contractor's solution shall identify and deny or suspend duplicate or suspected duplicate claims across all claims transactions (e.g., fee for service, encounter) submitted by all enrolled providers, organizations, MCOs based on configurable business rules as defined by the Agency.

Team CNSI's solution includes rule engine, RuleIT that is pre-configured with medicaid claims edits, audits, and rules which also includes duplicate claim edits. Any claim that meets the duplicate criteria will either be denied or suspended for manual review. The evoBrix X Core Claims module uses claims history information and current claims data when performing duplicate check logic. Our solution provides functionality for claims staff to define "exact duplicate" and "suspect duplicate" edit criteria. These duplicate criteria are managed through online screens as shown in Figure 3.10.10-28 and Figure 3.10.10-29. After checking for a duplicate claim, our solution determines whether a current claim is an exact or suspect duplicate of a previously paid claim. Upon finding a "paid" or to be paid" claim, our adjudication engine references the defined criteria to post edits where the configured elements are matching.

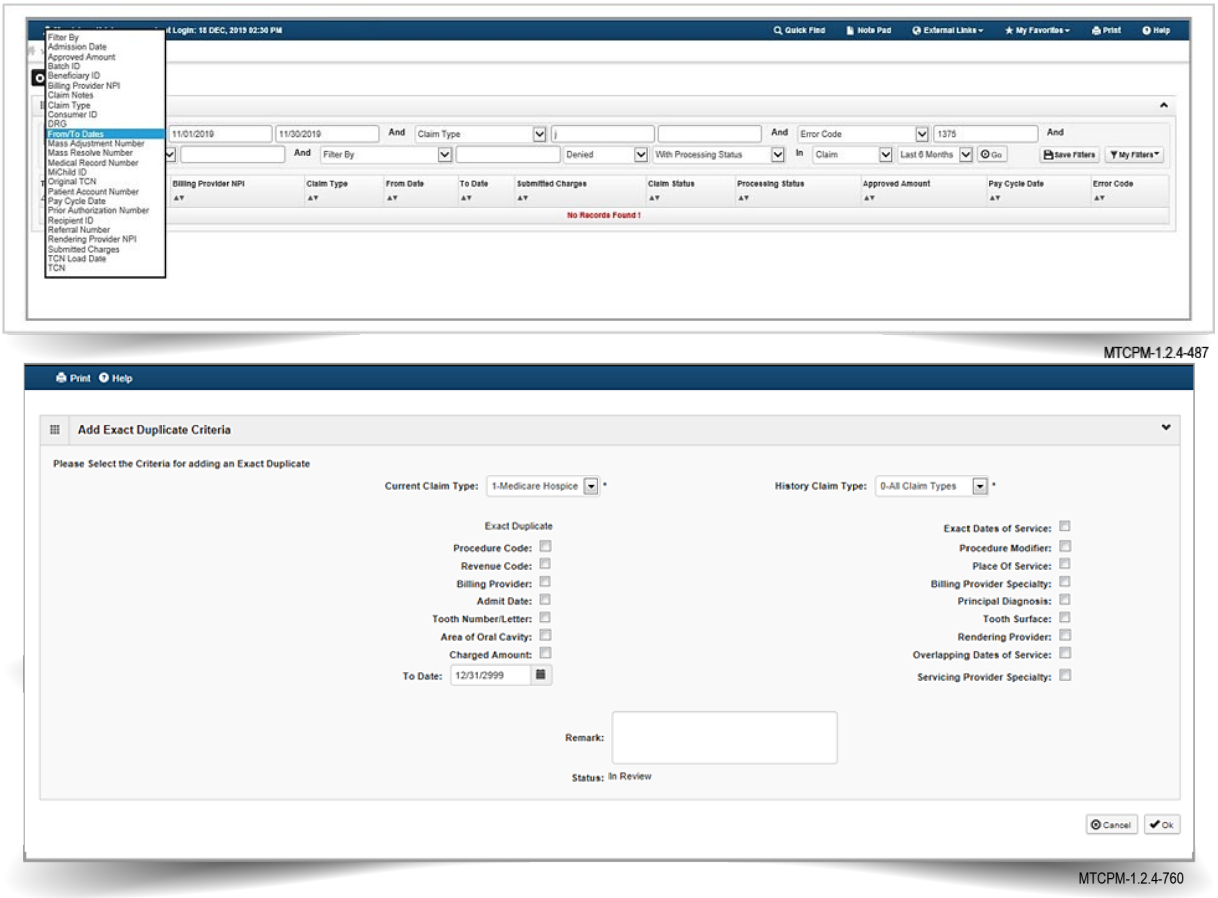


Figure 3.10.10-28. Exact Duplicate Audits. Exact duplicate criteria based on claim attributes are defined online by authorized users.

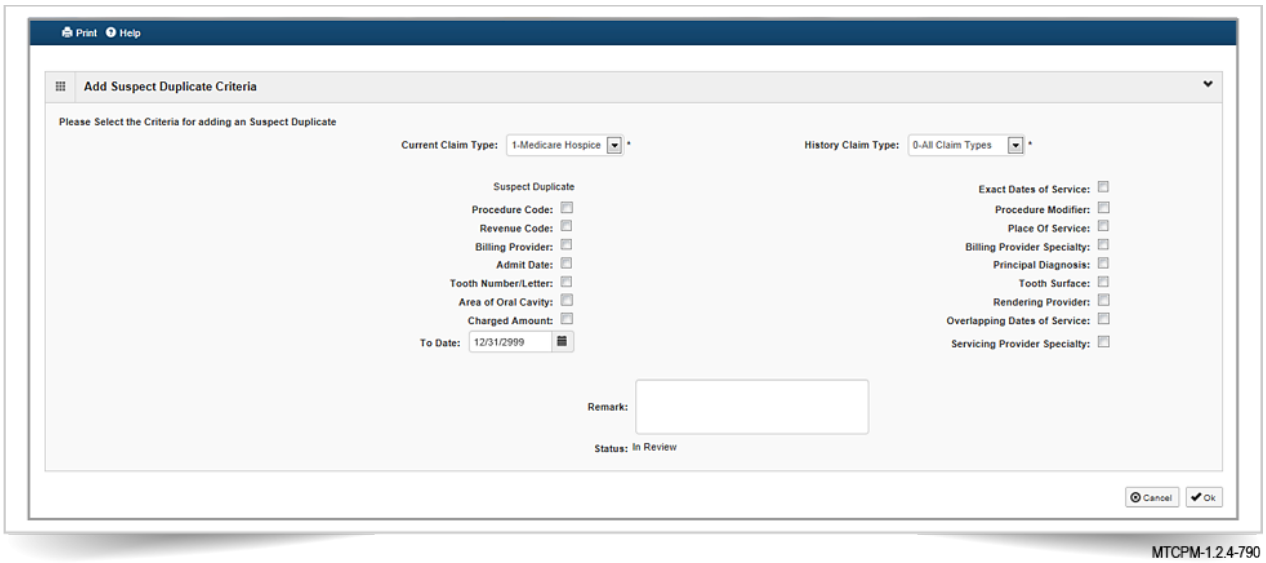


Figure 3.10.10-29. Suspect Duplicate Audits. Suspect duplicate criteria based on claim attributes are defined online by authorized staff.

EPA21

The Contractor's solution shall process and adjudicate all claims transactions using configurable business rules (e.g., bundle vs. unbundled, suspect or exact duplicates, invalid tooth number, age vs. procedure, category of eligibility vs. procedure, mutually exclusive, incidental, emergent visits) as defined by the Agency.

Team CNSI's evoBrix X CPMS adjudication process applies edit and audit rules for all modules as defined by the agency within the system. Team CNSI's solution supports all claims auditing specified in the solicitation, including audits related to duplicate check, reference, pricing, NCCI, limits, and conflicts. Solution also applies claims edits to ensure invalid tooth number, age vs. procedure, category of eligibility vs. procedure, mutually exclusive, incidental, emergent visits validation checks that are performed during the claim adjudication process. During claims adjudication, evoBrix X Core Claims will utilize the rules engine and the data maintained in the system to ensure all claims follow MPATH policies and rules. The base version of RuleIT has pre-configured edits and audit-related rules. These pre-configured rules will be in place for the MPATH implementation, either as-is or modified as needed to satisfy MPATH policies. Team CNSI will work with MPATH to configure rules throughout the term of the contract to address the requirement.

Bundling Edits. The evoBrix X Core Claims module leverages Groups feature to define the bundling of services. The solution is pre-configured for certain types of edit, example for lab services is show below Figure 3.10.10-30. The Groups feature will provide the flexibility and configurability to create or modify the bundling edits.

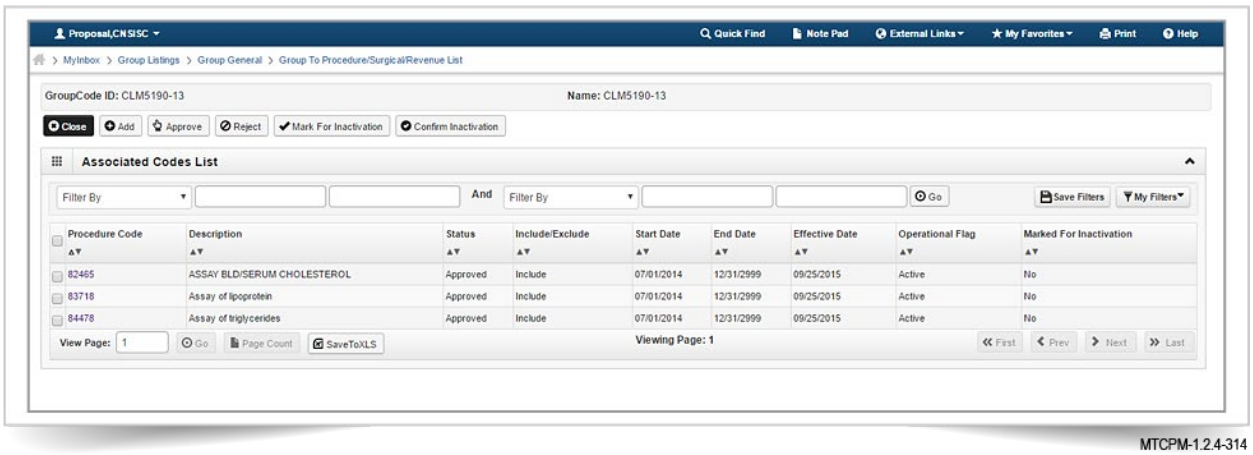


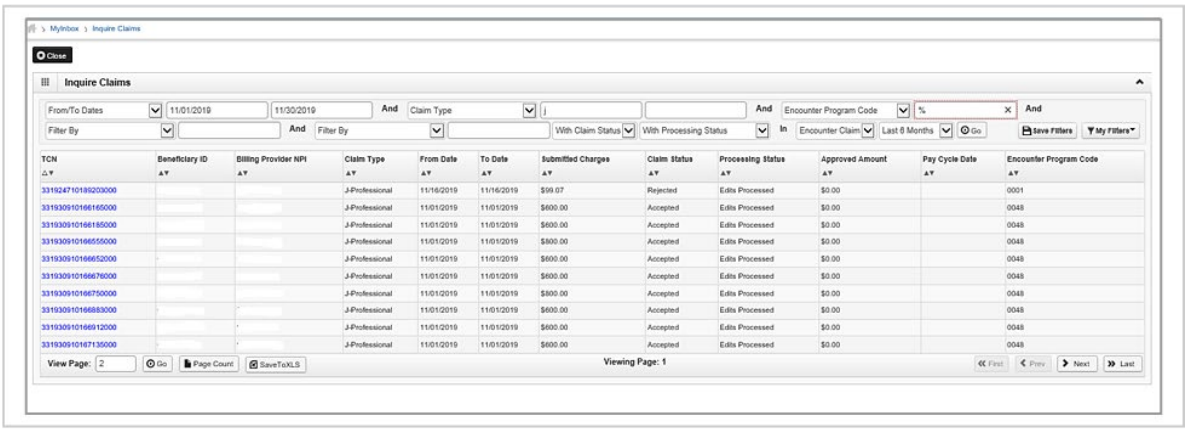
Figure 3.10.10-30. Bundling Edits in the Core Claims module. Setting up bundle groups is a simple configuration process in our solution.

EPA22

The Contractor's solution shall receive, process, and store encounter data from a variety of sources (e.g., Managed Care Health Plans, NEMT vendors) based on configurable business rules.

Team CNSI's solution comprehensively receives, processes, and captures all encounter data from a variety of sources. Encounters may originate from a variety of sources (e.g., Managed Care Health Plans, PIHP's, ICO's) and are stored and shadow priced in our solution. All encounters are submitted via HIPAA (837I, 837D, 837P) and the submitted encounter data get audited by applying edits and gets a disposition of either Accepted or Rejected. The system produces an Encounter Transaction Results Report (ETRR) report for the submitter.

Once encounters are received, a summary batch table is built with the batch number and number of claim documents in the batch. The number of Claim Documents Accepted and Claim Documents Rejected will be accumulated during the adjudication process. As the Medical Encounters are loaded, a TCN is assigned to each of the Claims as they are loaded. Medical Encounter Claims will be adjudicated exactly the same as FFS Claims with the exception that the Error Table for Encounter Claims will control the amount of editing performed on these Claims. Co-pay logic for FFS claims will be used to compute co-pay amount for encounter claims. Medical Encounter Claims are shadow priced based upon Medicaid pricing rules if there is enough valid information in the Encounter Claim to price it. The appropriate rate will be defined in the Reference Subsystem Rate Setting component for encounter shadow pricing. The Status code for Medical Encounter Claims will be Accepted or Rejected depending on the Error Disposition table for each error discovered during processing. As shown in Figure 3.10.10-31, encounters may be viewed online. Also, a batch job is executed daily to produce the ETRR. The report is sent to DPHHS defined sources and it provides information regarding accepted and rejected encounters. It also displays the number of Encounter Errors by Invoice Type posted by the Submitter if that TCN has ETRR flagged edit either on header or any line and displays the header details for Accepted TCN which does not have ETRR flagged edit posted.



MTCPM-1.2.4-315

Figure 3.10.10-31. Viewing Encounters Online. Team CNSI's Core Claims module provides powerful encounter processing capabilities to enable DPHHS to more effectively manage the Medicaid enterprise.

EPA23

The Contractor's solution shall, using configurable business rules, automatically review suspended claims based on Agency defined timeframes. The priority for these claims will systematically increase and where appropriate be automatically escalated for additional evaluation. All claims shall be electronically tracked until the claim is finalized.

Team CNSI's solution has an integrated workflow engine to assign claims to specific workgroups when the rule criteria are met. Assignment of the workgroup is driven based on claim parameters such as invoice type, claim type and the edit groups. The edit groups that suspend a claim for a valid business scenario can be configured in the workflow engine. The workflow engine will assign all such suspended claims to a special workgroup and will continue to monitor the action of the workgroup on the assigned claims. If no action or action has not been completed on a suspended claim within the timeframe defined by the DPHHS, our solution will automatically notify the supervising authorities to review the progress and take appropriate measures. The solution will be customized to support the automatic review of suspended claims based on Agency defined timeframes.

EPA24

The Contractor's solution shall automatically identify missing claims attachments (e.g., required forms, trip reporting, medical records) and automatically search the document repository for relevant documentation (e.g., a document associated to the member and service type for the attachment) and associate the document with the claim.

Team CNSI's evoBrix X CPMS comes pre-configured with the ability to identify missing claims via edits posted on claims missing attachments and initiate appropriate action manually. Agency staff are alerted to claims that do not meet documentation requirements should manual intervention be required. The solution will be customized to automatically search the document repository, FileNet, for relevant documentation and associate the document with the claim. Team CNSI uses high-speed scanners to produce images of scanned documents. Once scanned, the image is saved and uploaded into FileNet, the integrated document management system, for retrieval as needed.

As part of the imaging process, a unique TCN is assigned to each claim, piece of correspondence, or other attachment, and is printed on the physical document and the documents available in the FileNet will have proper indexing and meta data will help to search and associate the documents automatically to a claim.

This is used to track and maintain a claim and its attachments in the system and throughout the adjudication process.

EPA25

The Contractor's solution shall allow for user friendly manual entry of claims and adjustments by Contractor's and Agency staff.

Team CNSI's solution allows manual entry of claims and adjustments. Team CNSI will set appropriate permissions to enable authorized staff to enter claims. Our solution provides user-friendly screens for professional, institutional, and dental claims submitted on the evoBrix X Core Claims module through DDE and other online screens to process adjustments. DDE involves the use of web forms as shown in Figure 3.10.10-32.

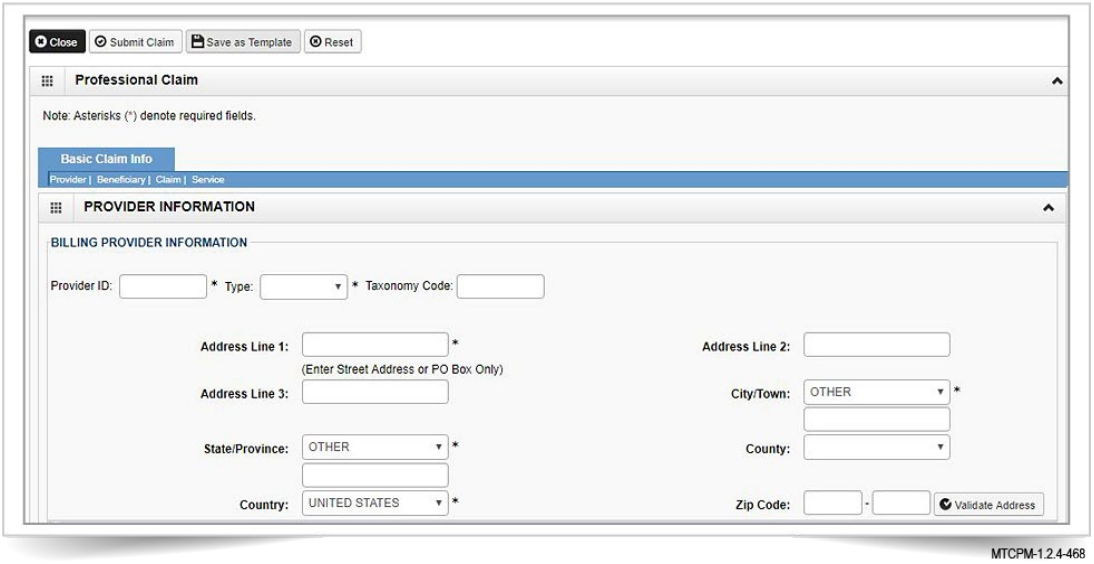


Figure 3.10.10-32. Manual Entry of Claims. The evoBrix X Core Claims module supports manual entry of claims using the online screens.

Our Core Claims module allows previously submitted claims to be retrieved via online screens to process adjustments using the 'Adjust' button at the bottom right as shown in Figure 3.10.10-33

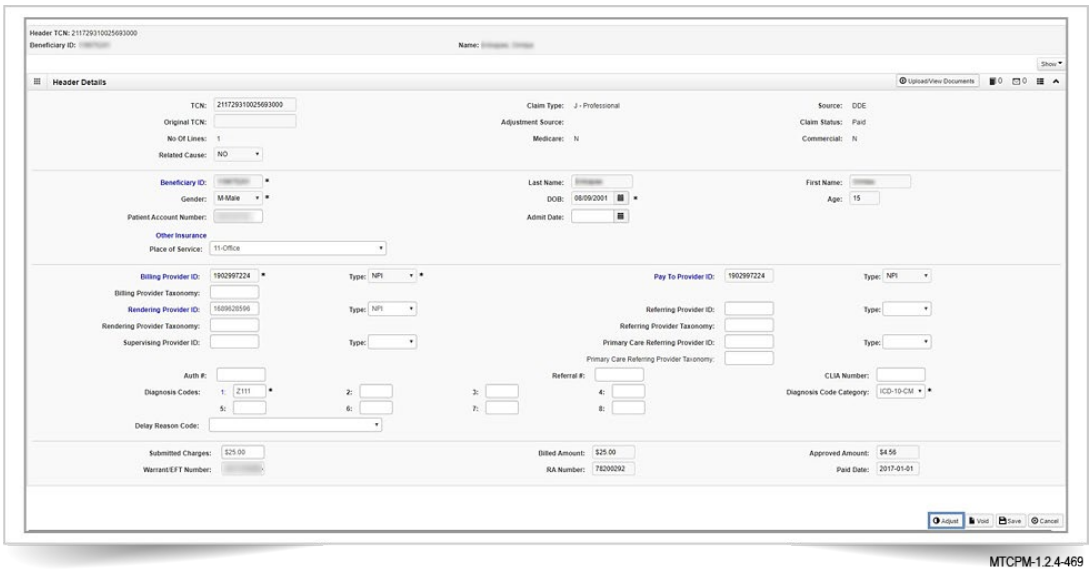


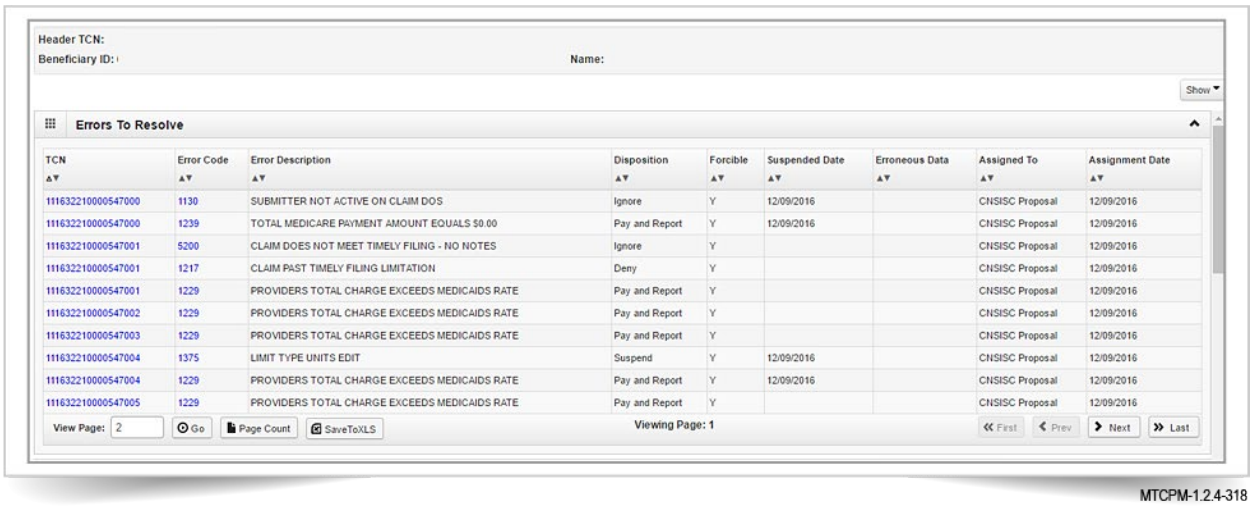
Figure 3.10.10-33. Manual Claims Adjustments for Previously Processed Claims. The evoBrix X Core Claims module supports manual claims adjustments using the online screens

The data captured using the online screens is validated for integrity with respect to the usage of procedure codes, revenue codes, and HCPCS Code among others. It is then ingested into the Core Claims module, where it is routed to the claims loading process for adjudication.

EPA26

The Contractor's solution shall identify, store, and display and report all edits, audits, and exceptions (error codes) applied to the claim during processing and provide viewable audit trail for all edits and exceptions that are applied to a claim as it is processed, as defined by the Agency.

At every step of the adjudication process, business logic is executed, and any violation is captured via error codes. All the error codes along with the error description will be displayed in the claim details as shown in figure 3.10.1.X. The claim processor can access all the edits posted for a claim by clicking on the Transaction Control Number (TCN) of the claim. This action brings up the claim summary screen with all the errors attached to the claim listed at the top of the page. The claim processor reviews all the errors listed along with the dispositions and addresses them, as shown in Figure 3.10.10-34. The solution also maintains the historical errors logged on a particular claim as shown in Figure 3.10.10-35.



MTCPM-1.2.4-318

Figure 3.10.10-34. Errors to Resolve. This screen is used to point out each error code and disposition for that code, providing an easy reference for the reviewer.



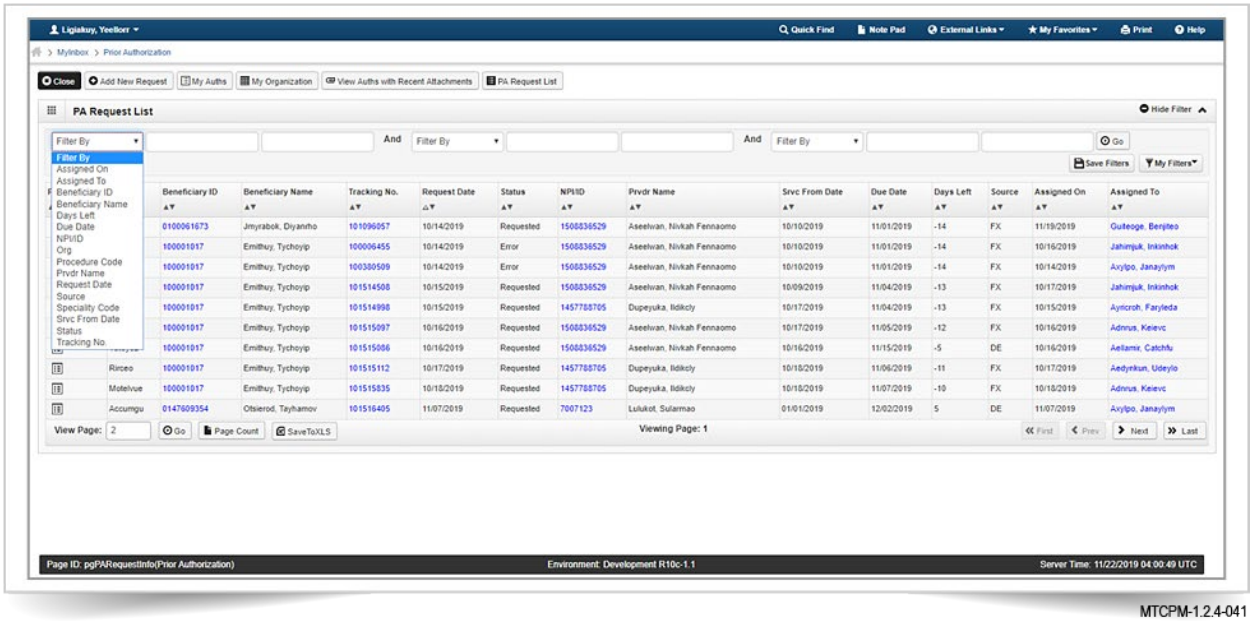
MTCPM-1.2.4-322

Figure 3.10.10-35. Errors History. Our solution provides a complete trail of errors logged on a claim.

EPA27

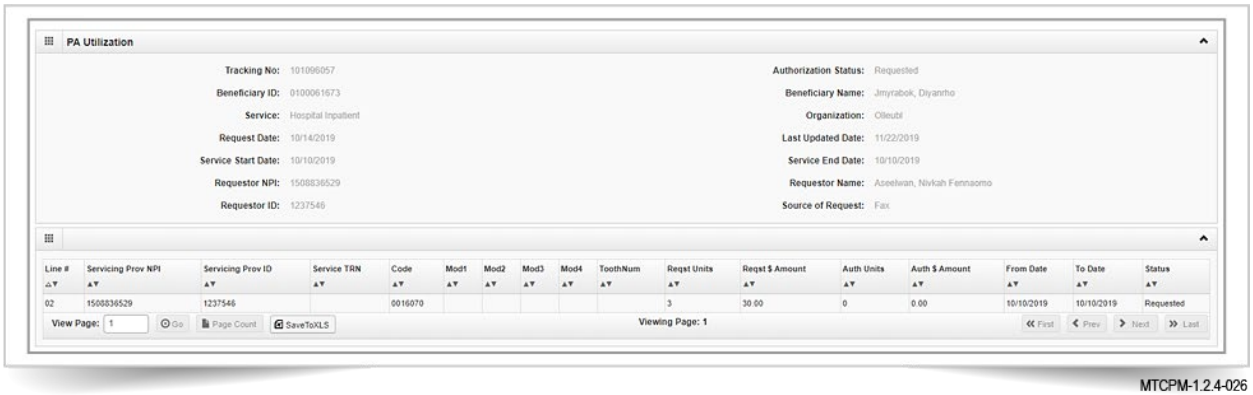
The Contractor's solution shall create notification for requesting and performing providers, case managers, authorized users and participants of service authorization activity, as defined by the Agency

Team CNSI's solution allows the provider to view the status of the service authorization activity at any time using online screens. Figure 3.10.10-36 shows a listing of service authorization requests submitted by the provider. The provider can further see details of a service authorization request by clicking on a service authorization from this list. These details are presented in Figure 3.10.10-37. DPHHS staff also will have access to these screens. Additionally, Team CNSI's solution will be customized to generate notifications to performing providers, case managers, authorized users and participants of service authorization activity, as defined by the Agency.



MTCPM-1.2.4-041

Figure 3.10.10-36. Service Authorization List Page. Our service authorization list page provides the capability to filter the listing using a variety of field combinations.



MTCPM-1.2.4-026

Figure 3.10.10-37. Service Authorization Tracking. Team CNSI's solution provides detailed tracking of Service Authorizations.

EPA28

The Contractor's solution shall adjudicate and finalize claims at a frequency (e.g., real-time, near-real-time processing, and batch processing where appropriate and/or necessary) as defined by the Agency.

Team CNSI's solution has the capability to adjudicate claims in real time, near-real time, and batch processing. Effective and timely claims processing is dependent upon accurate and reliable receipt of claims. Our solution processes batch processing is the normal mode in which claims adjudication is conducted. The cycle time for end-to-end claims processing depends on many factors such as business needs, claim volume, and system performance. Team CNSI will establish a desired cycle time in collaboration with the Agency. While nightly batch processing is the preferred option, the evoBrix X Core Claims module has the option to conduct real-time and near-real time claims adjudication, for scenarios that warrant this approach given that providers have varying needs and technical abilities for submitting claims. Team CNSI provides a full spectrum of capabilities to enable all providers to submit claims efficiently

based on their circumstances and preferences. Our solution allows providers to submit the claims using any of the following options:

- 837 file transfer through the EDI gateway
- Manually uploading EDI files in the Core Claims module
- Direct data entry
- Paper claims submission

EPA29

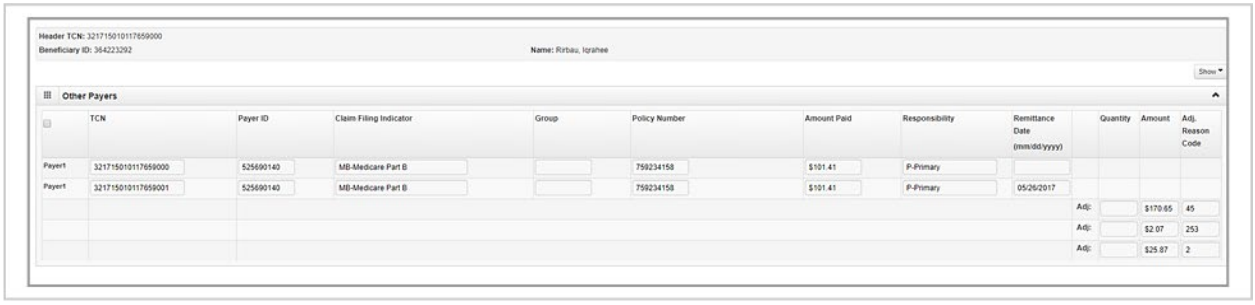
The Contractor's solution shall identify and utilize third-party and/or Medicare coverage/payments at the header or line level to pay (e.g., pay in full, pay reduced amount, pay at zero, or pay coinsurance and deductible) or deny as defined by Agency business rules.

The evoBrix X Core Claims module validates the claims data against TPL data to identify TPL discrepancies. The claim will be suspended with appropriated edits if the module identifies any discrepancies. After the successful validation of TPL information, the module applies appropriate pricing logic to utilize third-party and/or Medicare coverage/payments during Claim adjudication.

Team CNSI's solution supports receipt and processing of Medicare crossover claims. Special rules are configured in RuleIT for the processing of these claims. This includes the logic to compute the Medicaid payment amount to be the lower of Medicare patient responsibility amount or the difference between the Medicare payment and the allowed Medicaid payment amount. The system ensures that no amount will be paid on the claim, if the Medicare Paid Amount exceeds the Medicaid allowable payment amount. TPL validation is an integral component of the adjudication flow in our solution. Appropriate actions will be triggered based on the outcome of TPL validation, including:

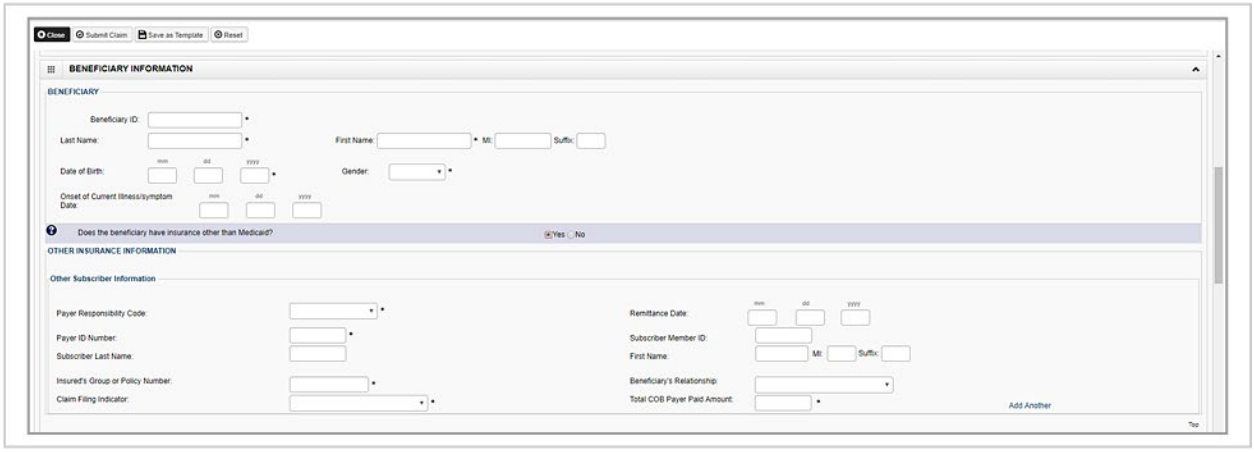
- Denying claims when it is found that the member has active third-party coverage
- Deducting from the to be paid amount, the amount that the identified third party is liable to pay
- Deduction of the third party's liable amount when calculating the to be paid amount

Team CNSI's solution also allows DPHHS to view the TPL data associated with the claim using screens as shown in Figure 3.10.10-38 and also allows the provider to enter TPL details while entering claim using evoBrix X screens as shown in Figure 3.10.10-39.



MTCPM-1.2.4-323

Figure 3.10.10-38. TPL Listing Viewed Online. Team CNSI's solution enables users to view other payer payment details associated with TPL Claims



MTCPM-1.2.4-324

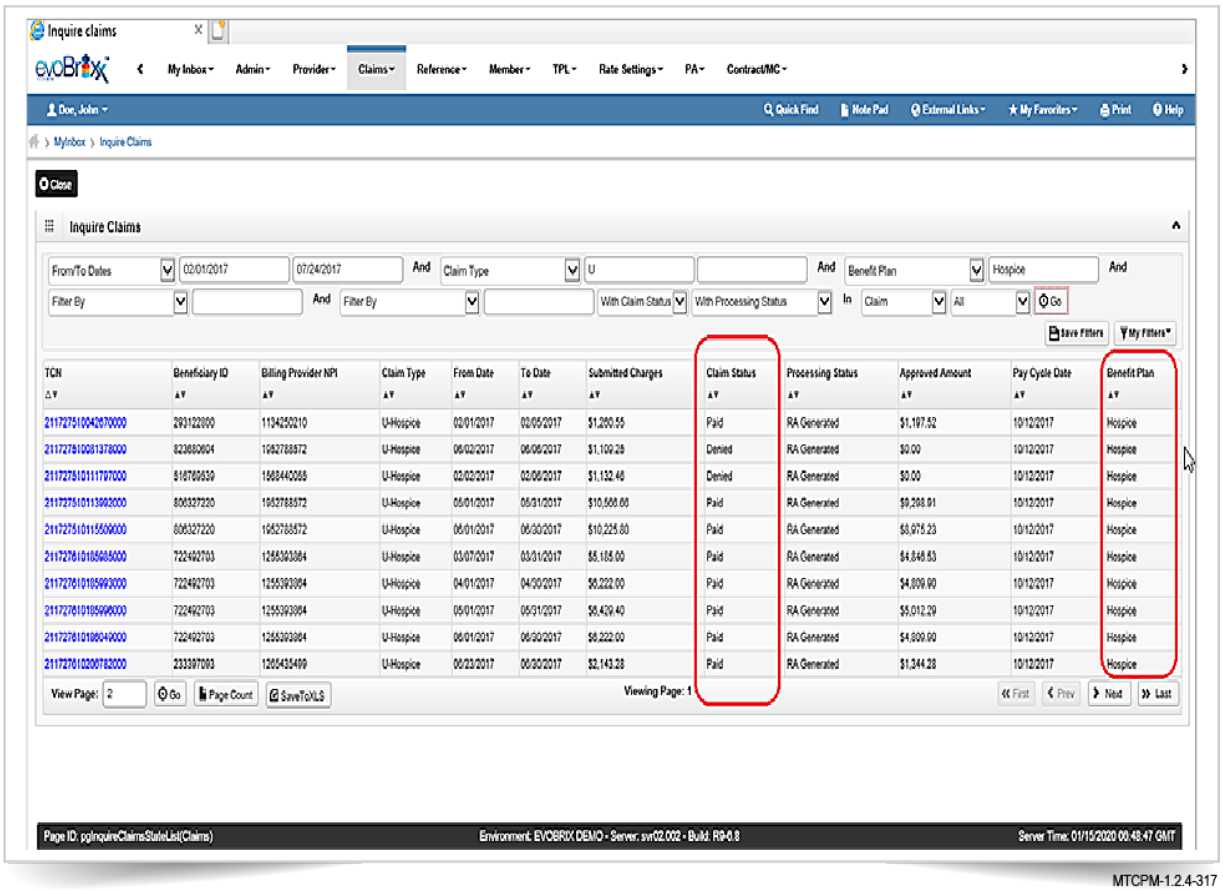
Figure 3.10.10-39. Entering TPL Information Online. Other payer information entered while submitting claims through evoBrix X Core Claims module online screens.

EPA30

The Contractor's solution shall process all claims transactions utilizing specific information contained in a benefit plan (e.g., member's healthcare coverage, provider, procedure/service, cost share, diagnosis) using Agency defined configurable business rules.

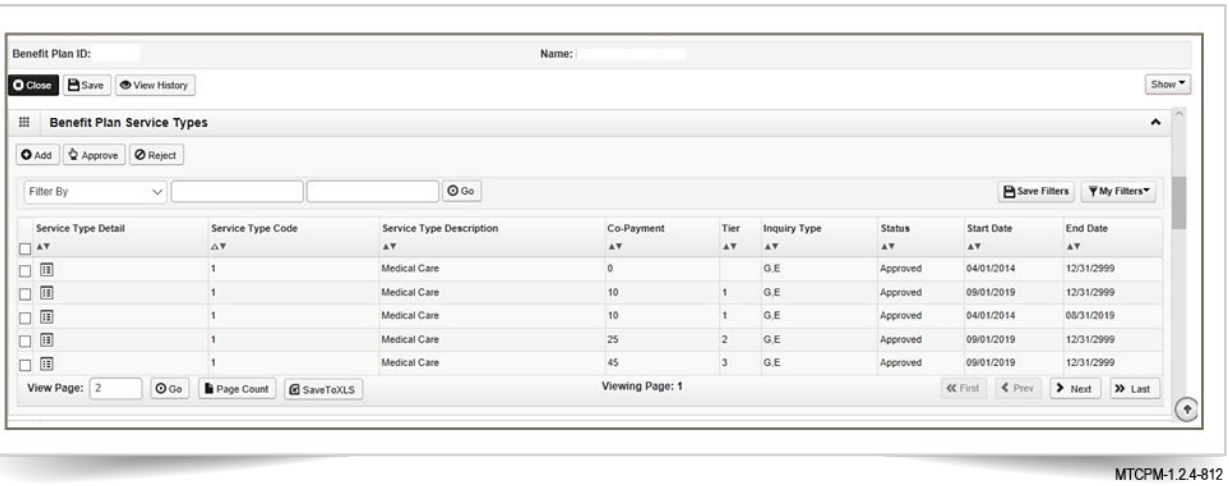
Team CNSI's solution will process claims using edits and business rules during adjudication to validate transactions against benefit plan information. Benefit Plans (BPs) are used to define the various groups of services offered by our solution. As shown in Figure 3.10.10-40, Team CNSI's evoBrix X solution includes a Benefit Plan component that helps in supporting the benefit plan assignment based on a member's eligibility code. Our solution has the capability to define the category of service through procedure codes, diagnosis codes, benefit limitations, provider exclusions, eligibility criteria (i.e., scope, coverage, program code, MAGI category, recipient aid category, and demographic information), effective dates, and member cost sharing. Eligible Medicaid members matching the configured characteristics are assigned to the benefit plan.

Benefit Plans are used to define the various groups of services offered by the State. Benefit Plan definition includes covered services as well as restrictions. The State defines services and eligibility requirements for each Benefit Plan along with co-existence rules, exclusion rules, and hierarchies. Benefit plans are selected for each claim line. When a member is eligible for more than one benefit plan, the pre-determined priority will determine the assignment. Claims will set the Multiple Eligibility Indicator (MEI) on the claim when co-existent Benefit Plans exist. This assignment process derives benefit plans based on member attributes and applies to all Claims, Adjustments, Voids, or Encounters (Shadow Pricing) that are submitted. The copayment can be configured in the Benefits Administration module for each service type (as shown in Figure 3.10.10-41) and the cost share can be configured for the benefit plans (as shown in Figure 3.10.10-42) based on the income, FPL and family size.



MTCPM-1.2.4-317

Figure 3.10.10-40. Benefit Plan Information. Team CNSI's evoBrix X CPMS captures benefit plan details to support claims adjudication.



MTCPM-1.2.4-812

Figure 3.10.10-41. Copay Configuration. Team CNSI's evoBrix X CPMS capability to configure copayments for benefit plans.

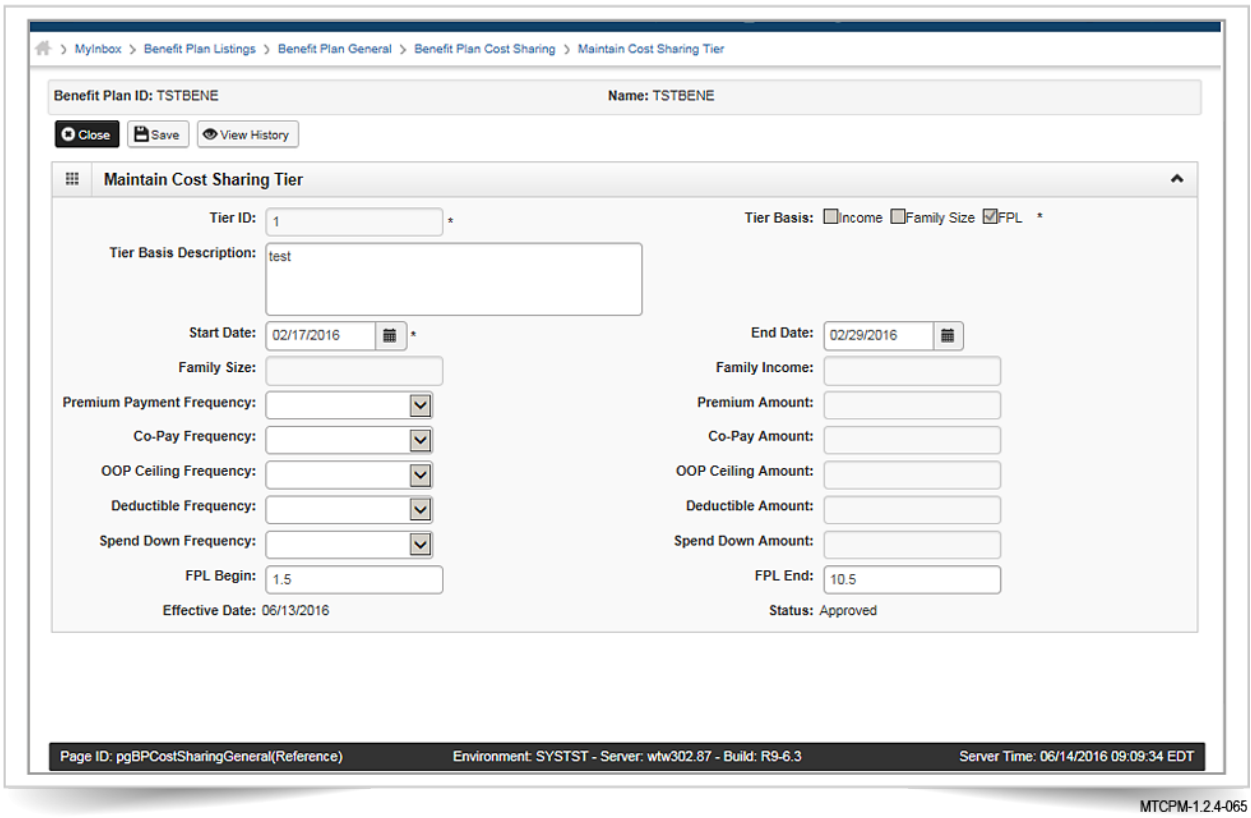


Figure 3.10.10-42. Copay Configuration. Team CNSI's evoBrix X CPMS capability to configure cost share for benefit plans

EPA31

The Contractor's solution shall identify, rollback/recover, reprocess and report on all claims transactions processed in error (e.g., system malfunction, sending or receiving error, Contractor's error) as defined by the Agency.

Team CNSI's solution allows the state staff to adjust or resurrect an already adjudicated claim to reprocess it to apply the right benefits and edits. The solution allows previously adjudicated claims to be retrieved via online screens to re-process the claim. Claims are resurrected or adjusted, through which an existing claim is reprocessed. Our solution provides the ability to prioritize and reprocess claims that are processed in error due to system malfunction or contractor error. The solution also has a mass adjustment functionality to reprocess claim that are identified for mass claim reprocessing through other mechanisms.

Mass adjustments is a highly automated process where operations staff uses online screens to enter criteria to identify the claims that need to be adjusted. The system has a range of options within the criteria fields that is made available to the claims processor for mass adjustment. Operations staff can enter different selection criteria from the various available options before submitting the request. Specific claims can also be directly selected for the mass adjustment process by operations staff without having to enter the selection criteria. After the selection criteria is entered on the mass adjustment screen, operations staff can submit the request. Upon the submission of request, the Core Claims module will identify all the impacted claims and will re-adjudicate during a nightly process and the claims will be ready for agency review for the final payment.

EPA32

The Contractor's solution shall provide the ability to process claims with Medicaid-covered, non-covered and non-healthcare services (e.g., DME, transportation, EPSDT, home modifications, waiver services) as defined by Agency configurable business rules.

Team CNSI's solution processes Medicaid-covered non-healthcare services, including waiver services. Waiver requirements are handled by configuring waiver programs as benefit plans having the relevant set of covered services. The benefit plan structure and configuration provide the flexibility to support waiver programs.

Claim edits ensure that billings abide by client and carrier-specific requirements and policies. Our team avoids missteps and greatly reduces the chance of unwanted member or carrier abrasion that comes from issuing claims related to waiver services, or excessive amounts of claims to carriers, for services that will never be paid, such as non-covered, Medicaid-only procedures

EPA33

The Contractor's solution shall provide the capability to waive timely filing on claims based on Agency configurable business rules.

Our solution provides flexible and configurable edit processing capabilities to activate or inactivate any pre-configured edits for claims processing to meet DPHHS business rules to waive timely filing on claims either at claim header level or at claim line level for a specific claim type and/or for a specific claim category and for a specific time period. Specifically, our solution includes the following edits which have been configured in prior implementations that will enable the Agency to waive timely filing on claims:

- Edit 1217 - Claim past timely filing limitation
- Edit 5200 – Claim does not meet timely filing

EPA34

The Contractor's solution shall accept, validate, and process all current and future approved HIPAA ASC X12 transactions from covered entities (e.g., health plans, health care clearinghouses, billing companies, trading partners, and health care providers)

The evoBrix X solution currently validates and processes the HIPAA transactions listed below. These transactions can be submitted by health plans, health care clearinghouses, billing companies, trading partners, and health care providers via the EDI gateways or self-service portal.

- 270 – Eligibility, Coverage, or Benefit Inquiry
- 271 – Eligibility, Coverage, or Benefit Information
- 276 – Electronic Claim Submission System Request
- 277 – Electronic Claim Submission System Response
- 835 – Healthcare Claim Payment Advice
- 837D – Healthcare Claim—— Dental 837I – Healthcare Claim — Institutional
- 837P – Healthcare Claim — Professional
- 999 – Functional Acknowledgment
- TA1 – Interchange Acknowledgment 278 – Prior Authorization Request
- 278 – Prior Authorization Response
- 834 – Benefit enrollment and maintenance
- 820 – Premium Payments
- 997 - Functional Acknowledgment

- 824 - Application Reporting
- 277U- Health Care Claim Status Notification - Health Care Payer Unsolicited Claim Status

Whenever a new HIPAA X12 transaction version is mandated, following the change management process, Team CNSI will conduct collaboration sessions with State team and finalize the release schedule. Based on the new rules, we will customize the evoBrix X CPMS and the EDI gateway to accommodate the new standard. Team CNSI's solution assumes that any EDI transactions that are mandated to be implemented by 3/2021 (the end of solution phase design) will be included in the MT CPMS go-live release. If any mandates are identified after 3/2021, we will collaborate with DPHHS through the change management process to define the best approach to scope, plan for and integrate these changes.

EPA35

The Contractor shall have an online solution for providers to complete submission of claim transactions with efficient keying of claims without requiring additional keystrokes such as slashes, dashes or double entry (e.g., allow providers to submit individual and/or batch claims file, allow providers to submit through direct data entry, allow providers to submit adjustments, voids, replacements, and corrections to existing claims as well as resubmissions of denied claims, allow providers to submit service authorization requests, allow providers to submit required participant attachments, forms, and requests for information, including the ability to submit supporting claims documentation, allow providers to review upfront validation of claims data at the point of entry by the billers, and allow for necessary correction) and allow for any additional types of submissions as defined by the Agency.

To ease the task of keying a claim into the Core Claims module directly, Team CNSI's evoBrix X Core Claims module provides screens that are similar to the CMS-1500, ADA and UB-04 forms. This online solution allows providers to complete submission of claim transactions with efficient keying of claims without requiring additional keystrokes such as slashes, dashes or double entry. Team CNSI's evoBrix X Core Claims module allows providers to:

- Submit individual claims through Direct data entry (DDE) and 837 file uploads; and as paper claims. And have the option to do a batch submission through the EDI Gateway.
- Retrieve previously submitted claims via online screens to process adjustments and voids.
- Submit replacement claims through the mass adjustment process. And mass void claims through the same process.
- Correct existing claims by adjusting the claim.
- Resubmit denied claims - Claims are resurrected or adjusted, through which an existing claim is reprocessed. Team CNSI analyzes, corrects, and resubmits rejected claims until we determine that the claim has been correctly paid and processed or validly denied.
- Submit service authorization (Prior Authorization) requests through DDE (Direct Data Entry) screens.
- Submit attachments, forms supporting claims documentation through the following mechanisms: Fax, Mail and Electronic upload via the online provider portal
- Easily access real-time information, including the following:
  - Perform status inquiries of claims and prior authorization requests
  - View remittance advice lists with details on pay cycle dates, charges, and payment amounts, along with the claim's summary for each RA
  - Perform status inquiries of member eligibility and date spans, as well as member benefit plan and services covered under the benefit plan
- Review upfront validation of claims data at the point of entry and allow for necessary correction. The main features of the DDE Service include:
  - Validation of claims data as it is entered

- On screen error messages when error conditions are encountered, thereby giving the user an opportunity to correct the data at the point of entry to prevent incorrect data from entering the system
- Ease of claims entry due to informative messages
- Reduction in claims suspension because of immediate data validation, ensuring quality claims data enters the system

EPA36

The Contractor's solution shall accept and process all current and future paper claim types (e.g., CMS 1500 (Professional Claim form), UB04 (Institutional Claim), ADA (Dental Claim) and paper adjustments as defined by the Agency.

Team CNSI's evoBrix X CPMS solution accepts and processes paper claim and paper adjustments (e.g., CMS 1500 (Professional Claim form), UB04 (Institutional Claim), and ADA (Dental Claim). Whenever a new version of paper claim type is mandated by CMS, following the Change Management process, Team CNSI will conduct collaboration sessions with the State team and finalize the release schedule. Based on the new rules, Team CNSI will customize the evoBrix X Core Claims module to accommodate the new standard. Team CNSI has decades of experience transforming structured forms, such as the CMS-1500, ADA, and UB-04 paper claims/paper adjustments, into usable data and easily retrieved images for use in downstream processes, as shown in the figures Figure 3.10.10-43, Figure 3.10.10-44, and Figure 3.10.10-45. The 'Source' field in these figures indicate that these are paper claims.

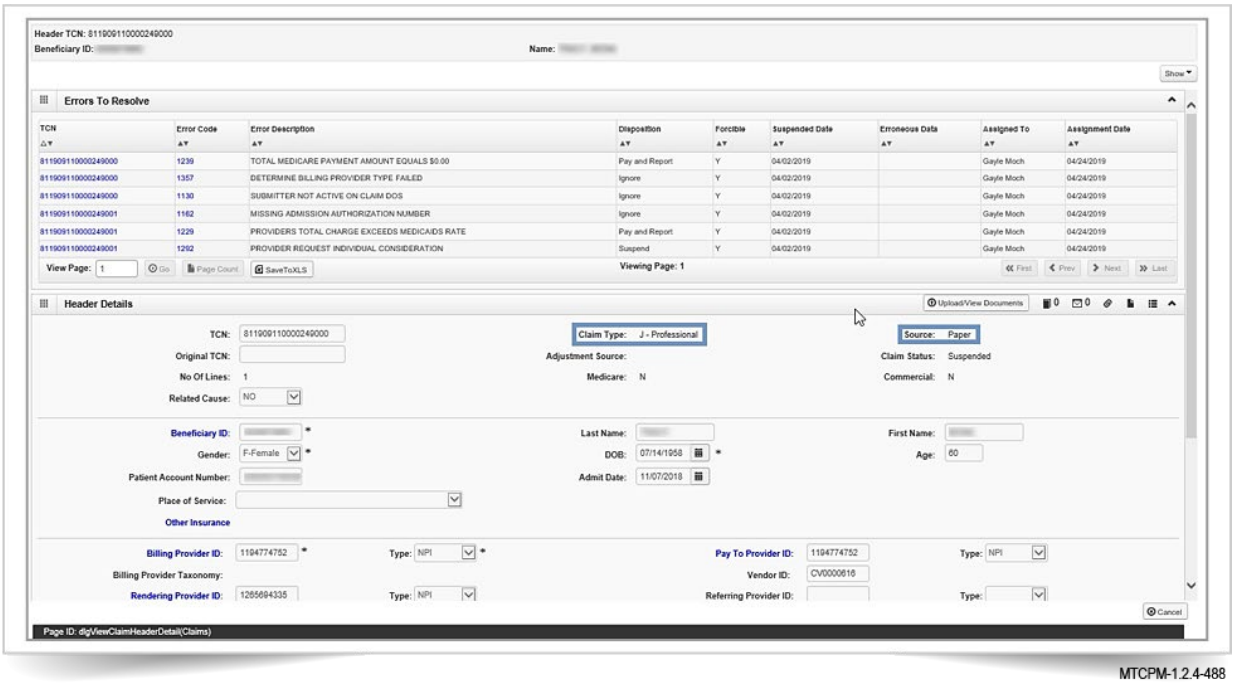
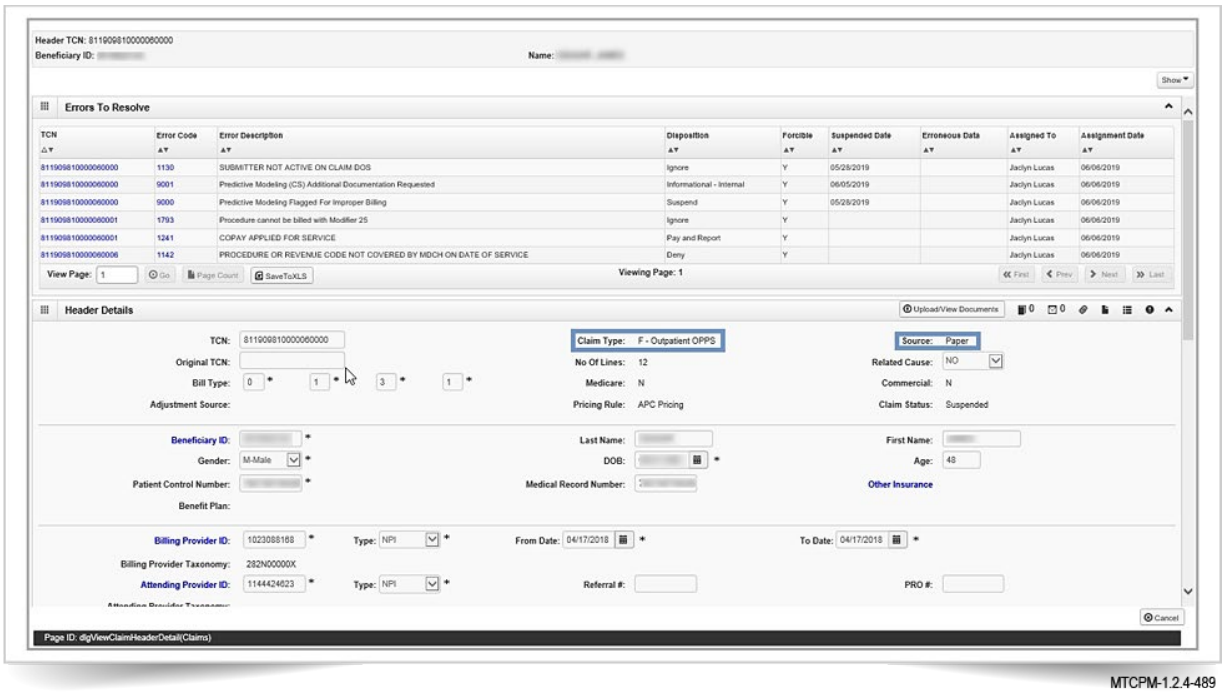
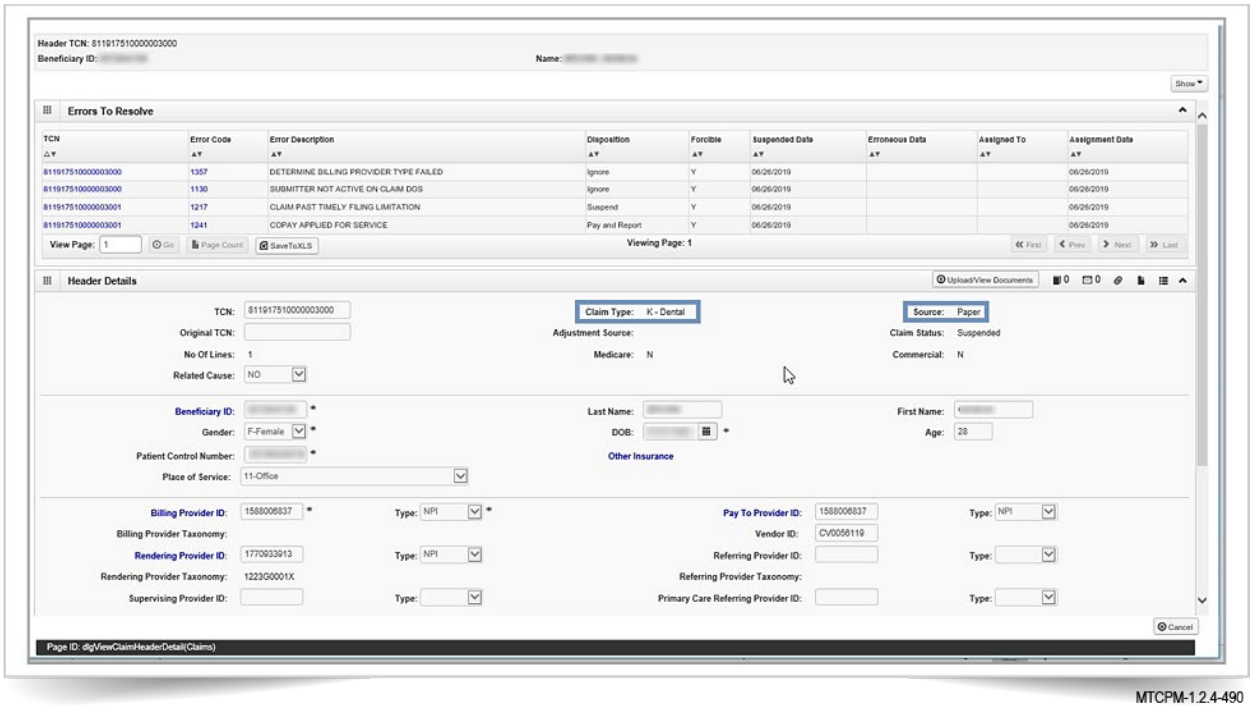


*Figure 3.10.10-43. Claim Detail Screen Showing Source: CMS 1500. The solution accepts and processes CMS 1500 p*aper claims.



MTCPM-1.2.4-489

Figure 3.10.10-44. Claim Detail Screen Showing Source: UB04 Paper Claim. The solution accepts and processes UB04 paper claims.



MTCPM-1.2.4-490

Figure 3.10.10-45. Claim Detail Screen Showing Source: ADA Paper Claim. The solution accepts and processes ADA paper claims.

The solution accepts and processes paper adjustments for CMS1500, UB04, and ADA claims. Regardless of source, our solution sets error code 1083 to indicate a claim the adjustment is in process as shown in Figure 3.10.10-46.

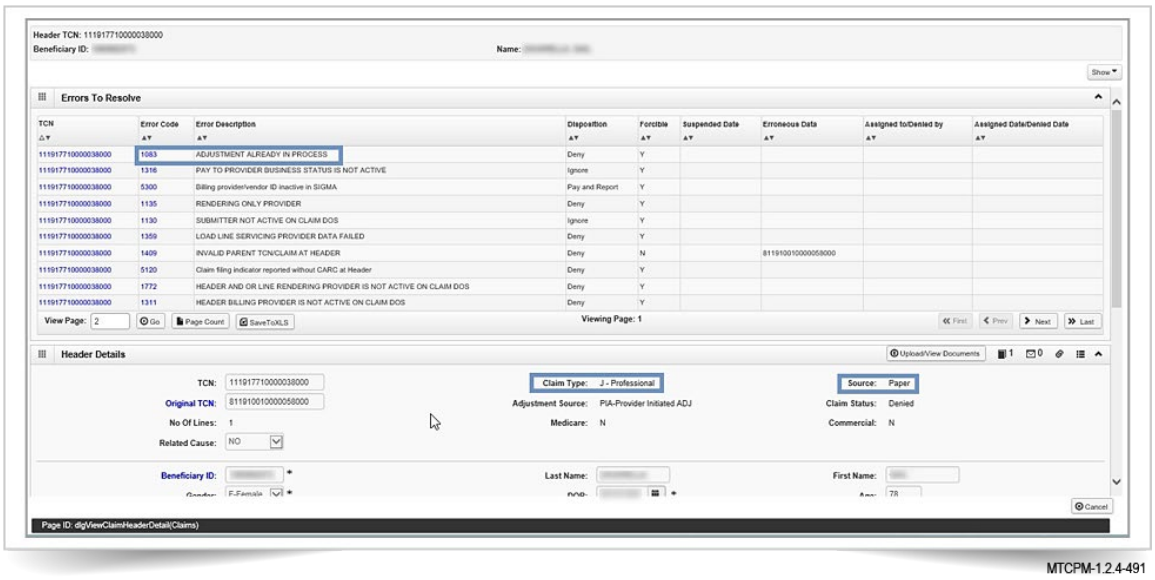


Figure 3.10.10-46. evoBrix X Core Claims Claim Detail Screen. The solution accepts and processes paper adjustments.

We perform the following steps during paper claims/adjustments intake:

1. All hard copy documents received in the mailroom are prepared for scanning.
2. High-speed scanners are used for producing images of hardcopy documents.
3. During imaging, a unique transaction control number (TCN) is assigned to each claim or piece of correspondence and printed onto the physical document.
4. The scanned image is saved and uploaded into FileNet for retrieval, as needed.

The TCN identifier assigned to the document provides the means for retrieving that document and any related documentation. This allows us to process and report status on documents throughout the claims life cycle. The TCN shows the actual business date of receipt, record type, batch number, and sequence number. Attachments receive the same unique identifier as the primary document to allow all related documents to be retrieved as a unit.

EPA37

The Contractor's solution shall display claims and associated documents which shall be searchable and printable as defined by the Agency

Team CNSI's solution provides intuitive search criteria for searches on claims and associated documents; both of which can then be printed. Providers use the Claims Inquiry screen where claims are displayed after a search is conducted as shown in the Figure 3.10.10-47.

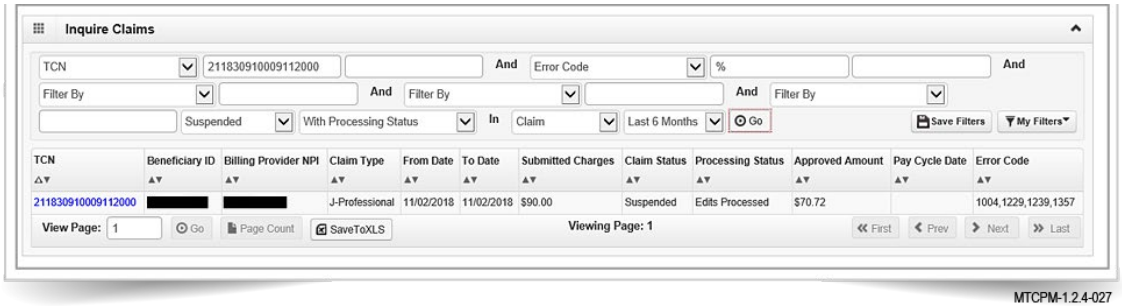


Figure 3.10.10-47. evoBrix X Core Claims Inquiry Screen. The Core Claims module offers a user-friendly interface to search on specific claims information.

To view documents associated to a claim, providers can click the 'Upload/View Documents' button on the Claim Detail screen. This navigates the provider to the document repository. Documents can be searched for using the TCN, Billing Provider ID, or the member ID as shown in the Figure 3.10.10-48.

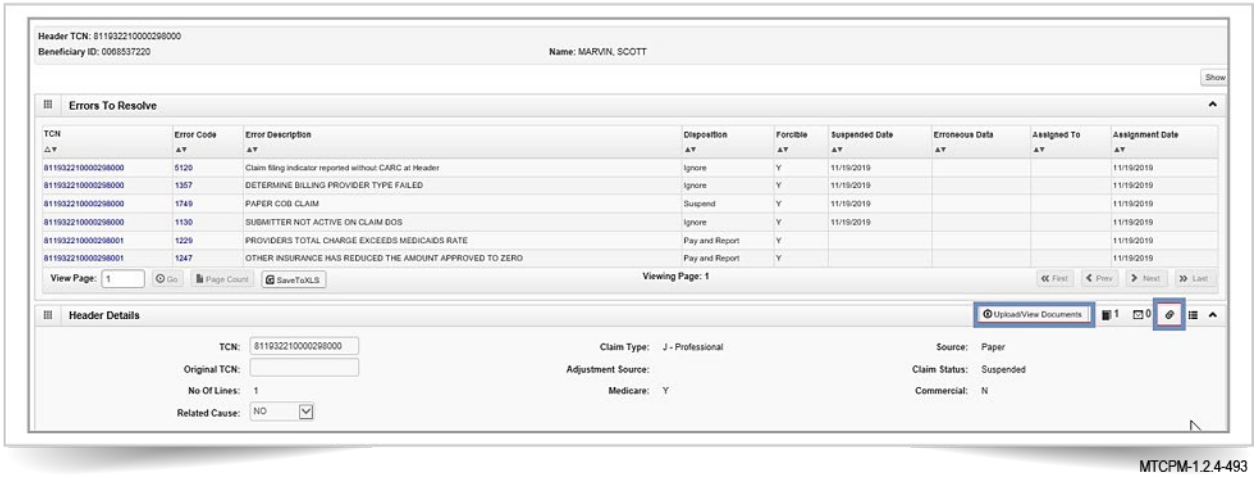


Figure 3.10.10-48. evoBrix X Core Claims Detail Screen. This screen offers providers options to view associated documents to a claim by clicking on the 'Upload/View Document' button.

Additionally, clicking on the paper clip displays the attachment list screen where and associated CMS 1500 paper claim document can be viewable, as shown in Figure 3.10.10-49.

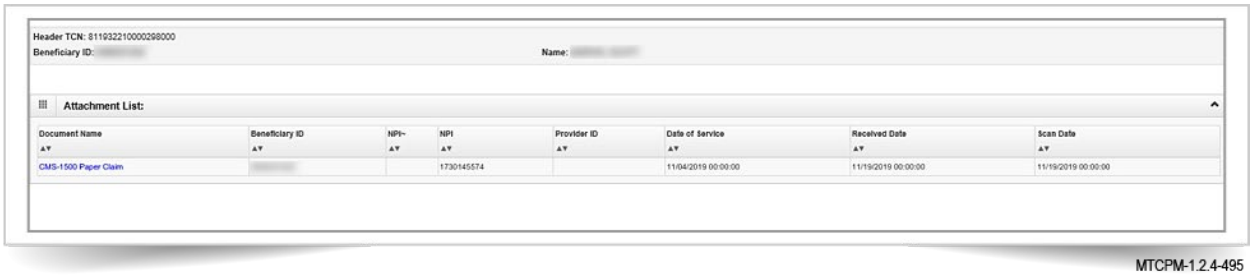


Figure 3.10.10-49. evoBrix X Core Claims Attachment List Screen. This shows CMS 1500 paper claim attachments received for that claim.

Figure 3.10.10-50 shows the screen for uploading documents.

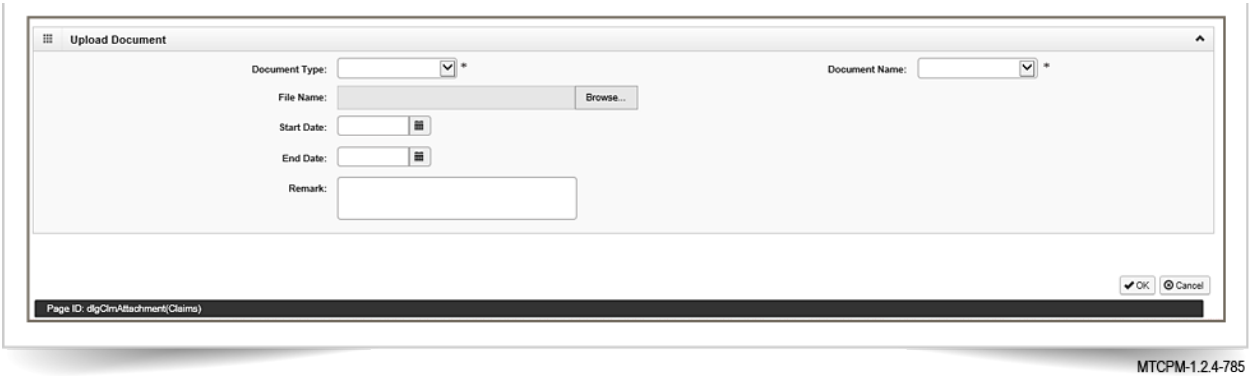


Figure 3.10.10-50. evoBrix X Document Repository. The upload criteria is used to attach documents to a claim.

EPA38

The Contractor's solution shall allow manual override of edits that do not suspend for manual intervention based on the Agency's configurable business rules.

Team CNSI evoBrix X CPMS makes use of Edit Disposition on how an edit will be handled by the system during claims adjudication when determining the claim status and Other configurable parameters related to an error code include the "Forcible" indicator, which allows the edit to be manually overridden by a Claims Resolver.



MTCPM-1.2.4-330

Figure 3.10.10-51. Error Management via Online Screens. Error Code Detail screen shows the flexibility and configurability of Error Codes in the evoBrix X Core Claims module. Modifying the information here alters the final status of the claim once adjudicated.

EPA39

The Contractor's solution shall have the ability to configure edit dispositions (i.e. deny, pay, pay and report, suspend, and super-suspend), as defined by the Agency's configurable business rules.

Disposition controls how an edit is handled by the system during claims adjudication when determining the claim status. Error code dispositions are configured based on the claim category (e.g., DDE, paper, system generated, replacement) and claim type (e.g., Inpatient, Outpatient, Nursing Facility). This functionality is especially helpful for defining new edits. For example, the Agency may choose to set up an edit to suspend claims for a period of time, to evaluate how it is posting, prior to setting up the same edit to automatically deny claims. Figure 3.10.10-52. demonstrates error disposition in the evoBrix X Core Claims module.

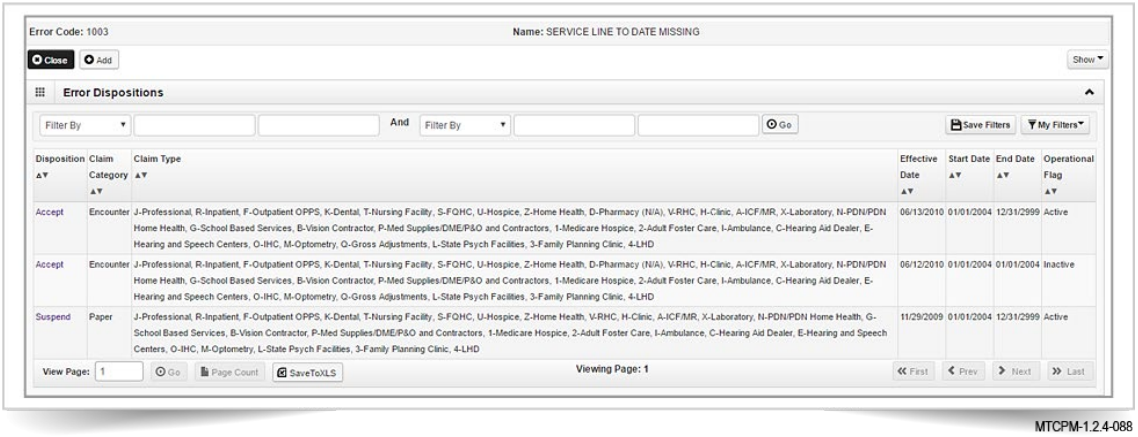


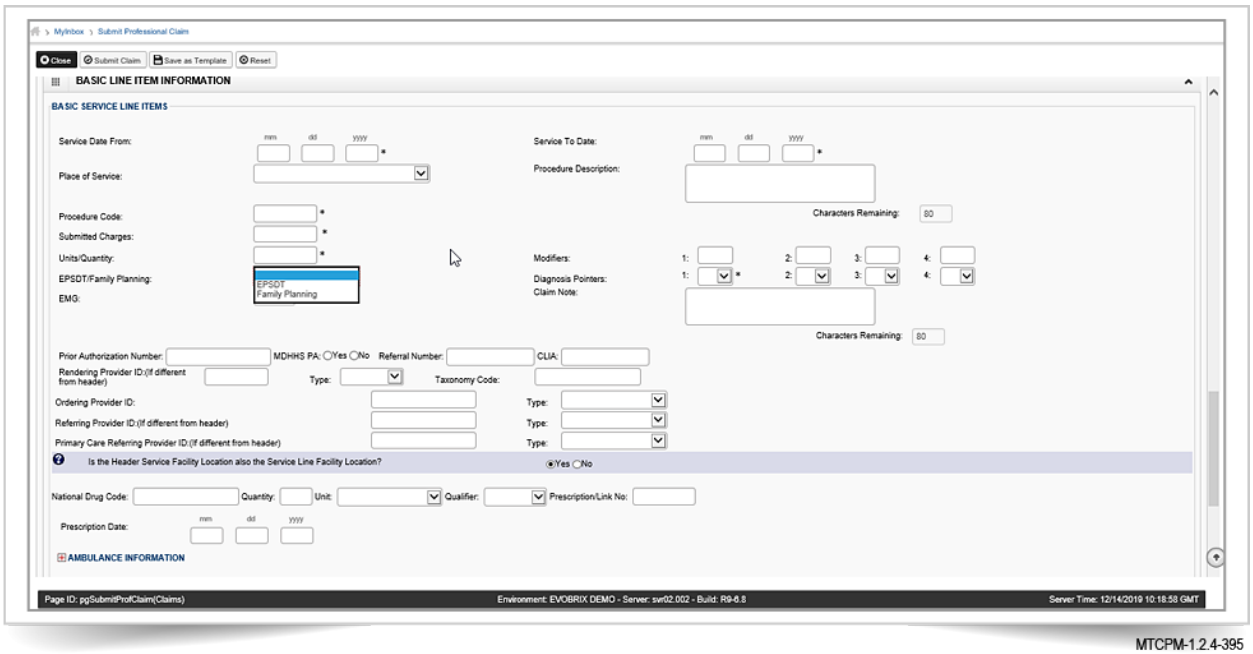
Figure 3.10.10-52. Error Disposition. Team CNSI's solution provides flexible and configurable edit processing capabilities to activate or inactivate any pre-configured edits for claims processing.

EPA40

The Contractor's solution shall provide the capability to apply and maintain edits and pricing rules for EPSDT related services or Agency defined name for a EPSDT program.

Team CNSI's solution enables a proactive medical services program for recipients under the age of 21. Its goal is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems in the early stages. Our solution supports DPHHS in the timely initiation and delivery of services. It also supports care management; federal reporting and follow-up treatment tracking with paid claims history and recipient eligibility.

Our solution maintains EPSDT eligibility and screening information as well as required demographic data on the member eligibility file and the EPSDT data structure, as shown in Figure 3.10.10-53. It generates notifications, referral notifications, and a state-defined periodicity schedule based on the information collected from the recipient eligibility file and the EPSDT data structure. Our solution derives indicators and flags during claims processing to brand and tag claims for reporting requirements. Our solution flags EPSDT, family planning, and sterilization claims for reporting.



MTCPM-1.2.4-395

Figure 3.10.10-53. EPSDT Data Entry. Our solution provides the capability of accepting and processing EPSDT related services.

EPA41

The Contractor's solution shall allow manual (e.g., force, deny, clear edit, super-suspend) and system overrides, and bypass criteria for edits on an individual claim or batch of claims including the source of the override as part of each individual claim record.

Team CNSI's evoBrix X Core Claims module enables system overrides and bypass criteria for edits on an individual claim or batch of claims are handled by configurable disposition processing. The system has the capability to define a default disposition of accept, deny, suspend, ignore (clear edit), and pay and report. Manual overriding and bypass criteria for edits (e.g., force, deny, release, refer) of an individual claim or batch of claims are handled via resolution process as shown Figure 3.10.10-54.

- Force: Allows the user to override and allow the service on an individual claim.
- Force All: Allows the user to override and allow the service on a batch of claims.
- Release: They can release the claim which sends it back through the adjudication process
- Refer: Allows the user to assign the claim to a specific individual for their review such as a nurse or an operations coordinator for support.
- Deny: Allows the user to deny the service line that set the error code.

The Core Claims module re-processes released claims from the suspend queue. As per Agency business rules and using the force and force all feature edits that are overridden with forcible flag will ignore/override the edit in the next run.

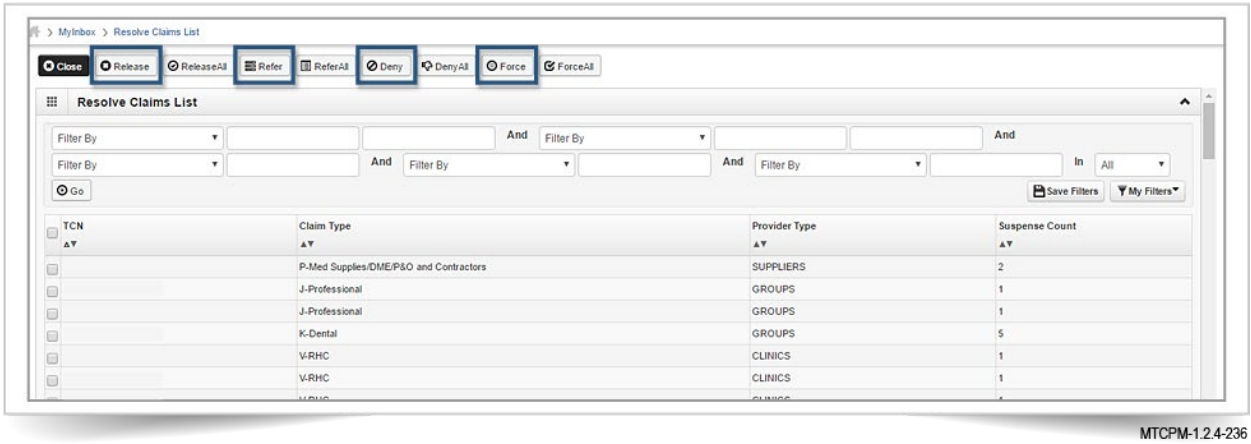


Figure 3.10.10-54. Resolve Claims List. The claims processors use this screen to resolve the suspended claim by taking one of four actions.

EPA42

The Contractor's solution shall receive, store, maintain, display, and use current and support all future versions of the Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules (CORE) standards: Claim Adjustment Group Codes (CAGC), Claim Adjustment Reason Code (CARC), and Remittance Advice Remark Code (RARC).

Team CNSI's CPMS adheres to CAQH CORE standards, including CAGC, CARC, RARC code sets. All EDI transactions are validated and processed per CAQH CORE standards. Team CNSI uses CARC to provide standard reason codes, as shown in Figure 3.10.10-55 and Figure 3.10.10-56. The CARC files are loaded and managed as other reference data. Our solution allows configuration of error codes that are mapped to the standard CARC codes. It also ensures that each error code posted on a claim, per the validation logic, has the associated standard CMS-provided CARC codes. Team CNSI will utilize CARC and RARC, as provided and updated by CMS. At every step of the adjudication process, business logic is executed, and any violation is captured via error codes. This error code signifies the violation of the rule and provides a description of the issues the claim encountered. Our solution then sends the adjustment reason codes and remittance remark codes on the 835 and paper remittance advice to providers explaining the adjustments and denial reasons. The RARC code data set may be administered in our solution as shown in Figure 3.10.10-57 and Figure 3.10.10-58.

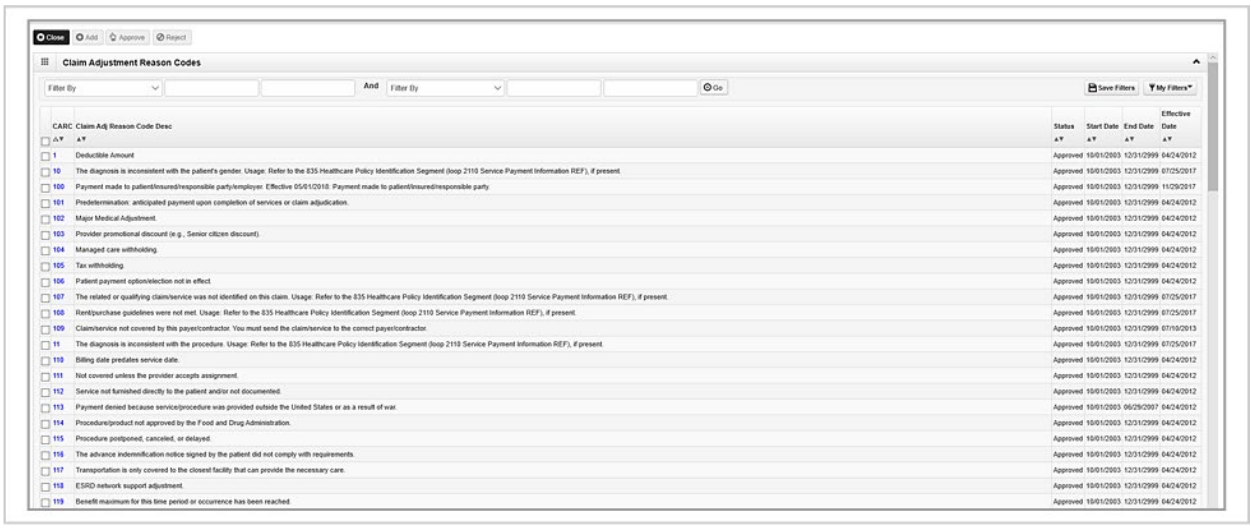


Figure 3.10.10-55. Claim Adjustment Reason Code. Team CNSI's Core Claims module supports standard claim adjustment reason codes.

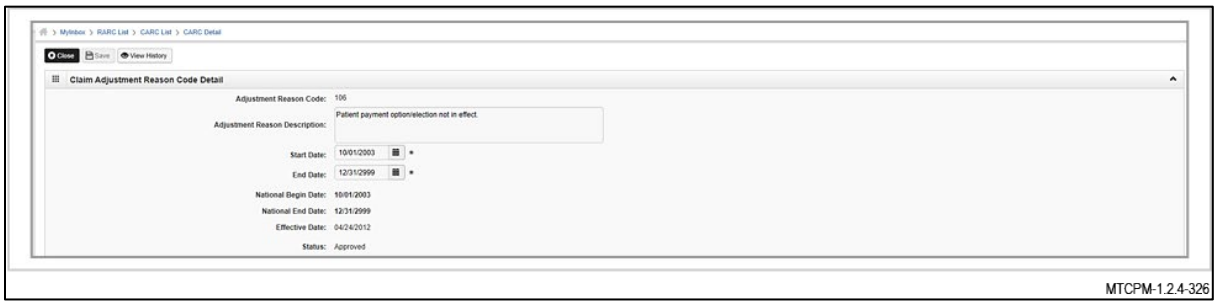


Figure 3.10.10-56. Claims Adjustment Reason Code Detail. CARC data may be configured through administration screens.

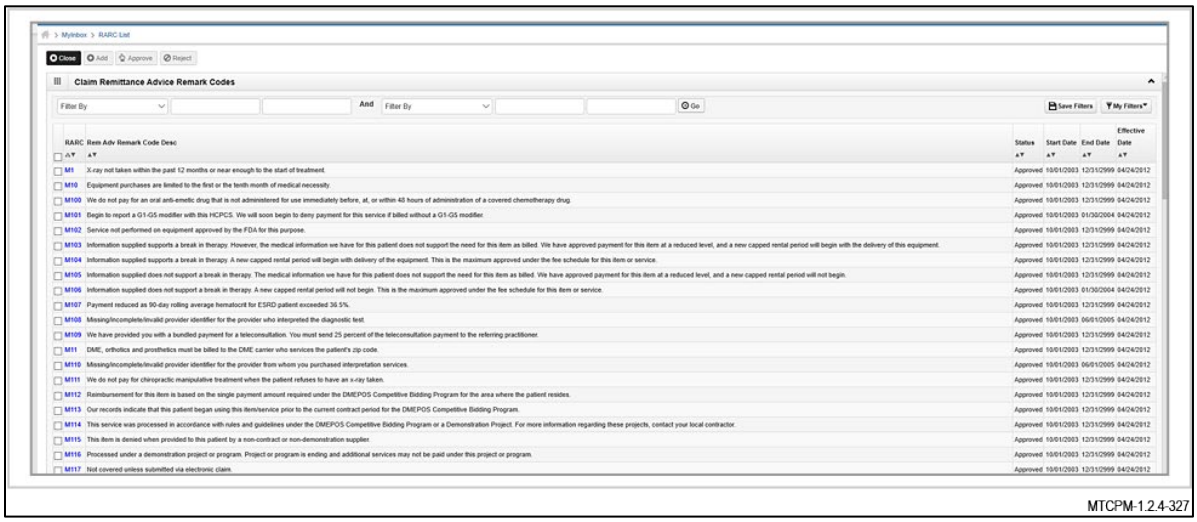


Figure 3.10.10-57. Remittance Advice Remark Codes. Team CNSI's Core Claims module supports remittance advice remark reason codes.



Figure 3.10.10-58. Remittance Advice Remark Code Detail. RARC data may be configured through administration screens.

Team CNSI evoBrix X solution provides similar capability to easily configure the Claim Adjustment Group Codes (CAGC) to support the Claim Adjustment for Explanation of Benefits.

EPA43

The Contractor's solution shall provide the ability to view summary level claim information for a member. Users shall have the ability to view utilization by service type (e.g., dental, vision, therapy), the ability to view header and line level edits, including the ability to filter the claims (e.g., date of service, date of payment, claim status, provider type, claim type, rendering provider, pay-to provider) as defined by the Agency.

Team CNSI's evoBrix X Core Claims solution provides an electronic user interface, via the Inquire Claims service (depicted in Figure 3.10.10-59), which enables providers to view the header, line level edits and the status of claims submitted in real time. The provider can use various filter criteria, which can be saved and reused, to limit the search.

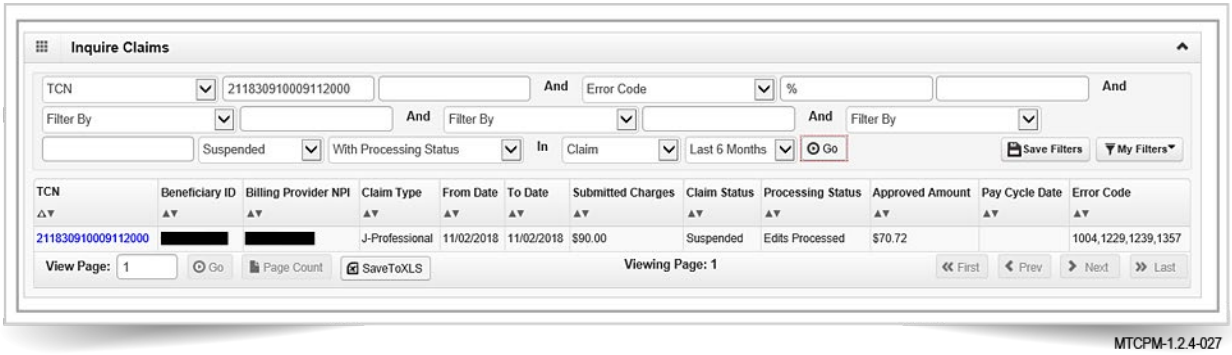


Figure 3.10.10-59. evoBrix X Core Claims Inquiry Screen. The Core Claims module offers a user-friendly interface to search on specific claims information.

The provider can view the claim details using the Inquire Claims screen, including the summary claim information, processing status, and errors posted on the claim, as shown in Figure 3.10.10-60.

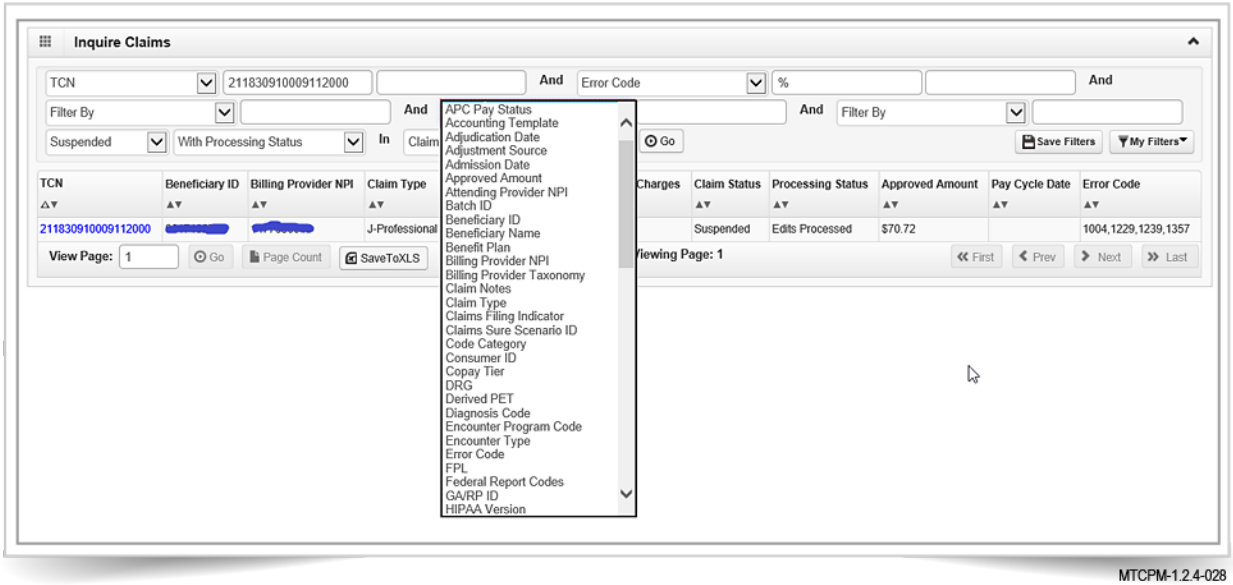


Figure 3.10.10-60. Inquiry Screen's Dropdown Menus. The dropdown menus offer providers an easy way to enter a TCN and filter criteria to view a claim's current status, processing status, approved amount, and edit error codes for which a particular TCN is either paid, denied, or suspended.

EPA44

The Contractor's solution shall have the ability to create, receive, maintain, and issue service authorizations for service(s) to be provided to a member with or without a specified provider using configurable business rules (e.g., service type) as defined by the Agency.

Team CNSI's solution provides Prior Authorization Management functionality that spans from PA intake to PA Processing and Inquiry. The evoBrix X Core Claims module has a comprehensive data model that supports the storage and maintenance of all prior authorization and service utilization information associated with claims transaction date. The evoBrix X Core Claims module will be customized to create a blanket service authorization for member without a specified provider. For the Blanket PA match logic, the Core Claims module will be enhanced to check that the claim From or To Date of Service (DOS) fall between the service authorization from and to dates, and the member matches. The Core Claims module uses Claim Header From or To DOS for Inpatient Claims and Claim Line From or To DOS for all other claim types.

EPA45

The Contractor's solution shall provide a service/prior authorization process that is flexible (e.g. across numerous programs, benefit plans, external systems interfaces, claim types, and services).

Team CNSI's service authorization solution, as describe in Figure 3.10.10-61, provides for the management of the full life cycle of service authorizations in a standards-based manner. The solution has the flexibility to handle all categories of X12 278 Request transactions including:

- Institutional/Professional/Dental
- Certification/Referral
- Our solution accepts HIPAA ASC X12 278 files and sends the appropriate response on the Outbound HIPAA ASC X12 278 file once a service authorization determination has been made. Service authorizations for physician-administered drugs and dental services performed in a medical facility in final status may also be submitted via HIPAA ASC X12 278 transactions. An automated HIPAA

ASC X12 278 response are sent to the entity submitting a HIPAA ASC X12 278 in final status provided there are no errors of the record. This response will contain the evoBrix X generated service authorization number that needs to be submitted on the claim.

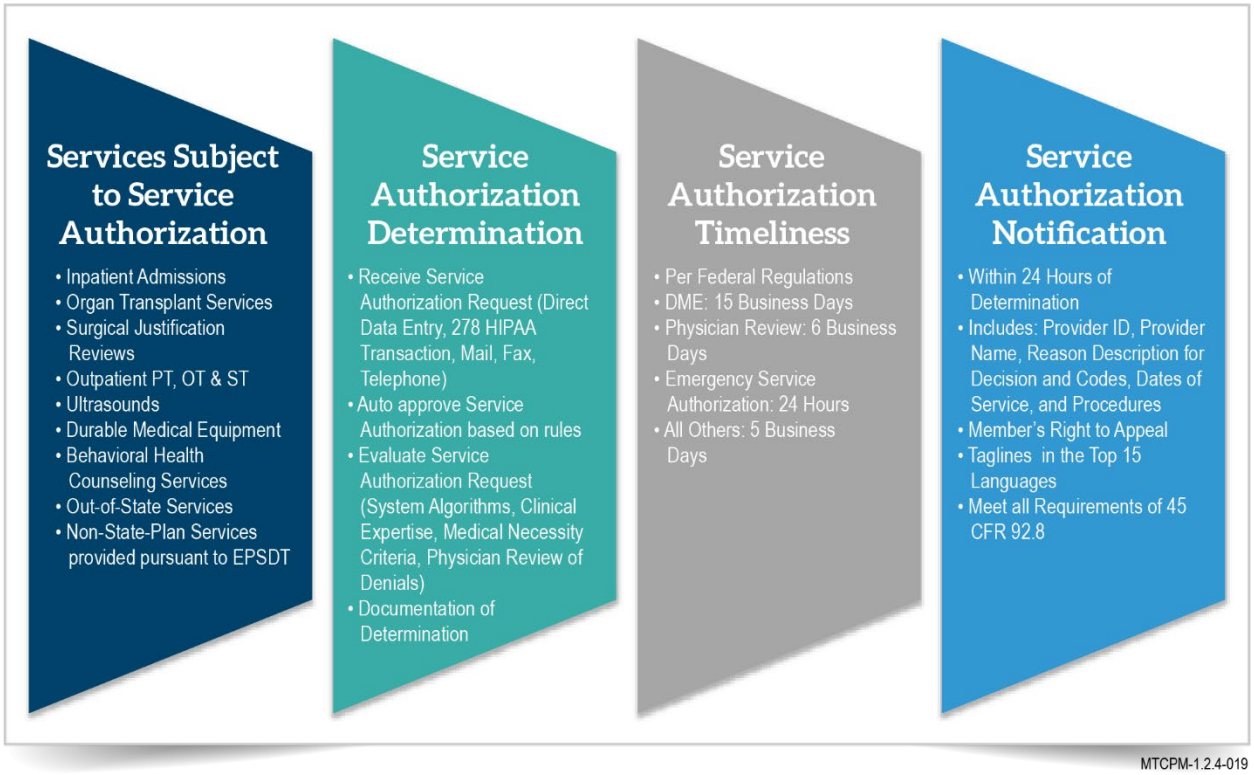


Figure 3.10.10-61. Service Authorization Services. Team CNSI solution provides a full spectrum of service authorization services based on proven experiences in multiple states.

EPA46

The Contractor's solution shall provide the ability to generate claim based event notifications to providers of required action (e.g., provide missing attachments) based on their preferred method of communication. The frequency (e.g., once per adjudication cycle) and content of the notification must be aggregated into a single event and configurable by the Agency.

Team CNSI's solution has capability generate the notifications or correspondences to Providers when the business conditions are met. Our solution has pre-configured notifications to provide status updates on the Provider Portal and with the generation of letters to providers. Following DPHHS-approved processes, including incorporating DPHHS input, Team CNSI will develop provider claims processing and payment communications materials and provide updated information throughout the contract period. Communication materials include provider notifications, provider manuals, newsletters, bulletins, RA banners, State memos, billing manuals, websites/portals, and privacy and security notifications. The frequency and the content on the notifications can be customized as per DPHHS's discretion. Team CNSI's solution requires customization if the notifications need to be sent to the Provider's preferred method of communication.

EPA47

The Contractor's system shall have the capability to create and maintain and configurable set of work queues to support the routing and assignment of suspended claims based on edits using Agency configurable business rules.

Our solution comes with an integrated workflow engine to manage the workflow for multiple business and operational processes. Team CNSI's evoBrix X Core Claims module supports workflow-based capabilities for multiple business and operational processes. The workflow is driven by defining business conditions and assignment rules. It also includes the ability to define user groups to which the tasks are routed. Users will be able to manage work using online resolution screens that enable assignment and referral of claims workflow items. Users will have the capability to archive tasks or reroute them for further investigation. The solution will flag and route claims for manual review, based on pre-configured edits. Additional edits required can be customized as per the DPHHS's business requirements. The solution can be customized to trigger any course of action based on a particular event. This includes a course of action that routes all suspended claims (except those that require DPHHS review) for manual resolution.

EPA48

The Contractor's solution shall automatically reprocess suspended transactions after any modification(s) or edit resolution(s) based on Agency configurable business rules.

Team CNSI's evoBrix X solution has a robust functionality to reprocess suspended claims after edit resolution or any modification to the claims data based on the agency defined rules. A claim is categorized as a suspended claim when it goes through the claims adjudication process and encounters edits errors that are configured to not pay or deny the claim. These claims need to be looked at manually and the errors identified in them resolved before passing them through the adjudication process again. The evoBrix X claims adjudication engine has error allocation rules that assign the claim intelligently to the right operations staff to resolve suspended claims. The system scans through all of the edits posted on a claim and, based on the specified rules, picks one of the edit's entities to assign the claim to that entity. The entity association to an edit is configurable. evoBrix X maintains a claims resolution location as a configurable element for an edit.

Claim processors access the list of suspended claims assigned to them for resolution using the evoBrix Resolve Claims List screen shown in Figure 3.10.10-62. The filter option on the screen is used to locate the assigned claims. The oldest claims in each queue are located at the top of the screen to ensure that those are worked on first, meeting the requirement to complete the claims (except those routed to DPHHS for review) within five business days of receipt.

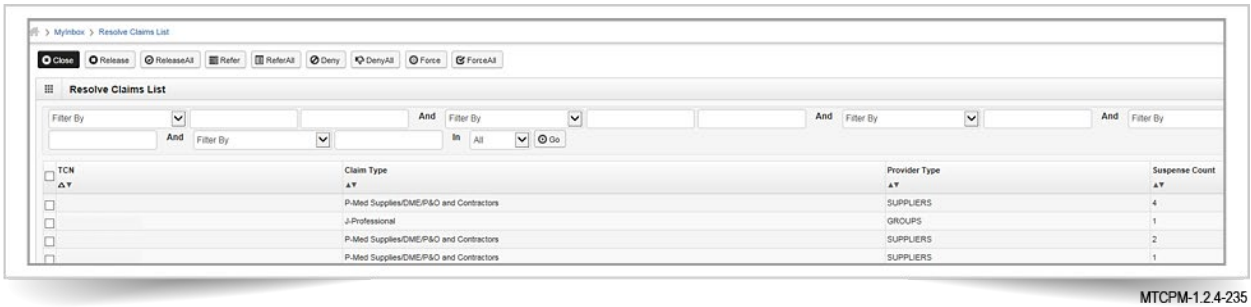


Figure 3.10.10-62. Resolve Claims List Screen. Claims processors use the filter option on this screen to quickly identify the claims they are assigned.

The claim processor can access all the edits posted for a claim by clicking on the Transaction Control Number (TCN) of the claim. This action brings up the claim summary screen with all the errors attached to the claim listed at the top of the page. The claim processor reviews all the errors listed with a disposition of "Suspend" and addresses them, as shown in Figure 3.10.10-63.

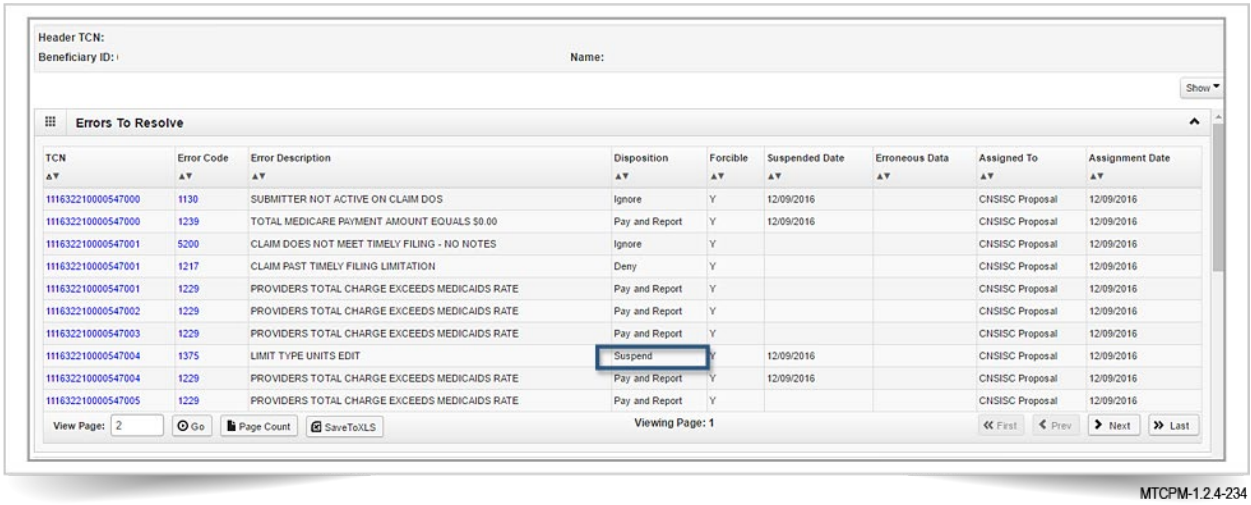


Figure 3.10.10-63. Errors to Resolve. This screen is used to point out each error code and disposition for that code, providing an easy reference for the reviewer.

The claims processor has the ability to click on the error code to get a full description of the error and the claim status, as shown in Figure 3.10.10-64.

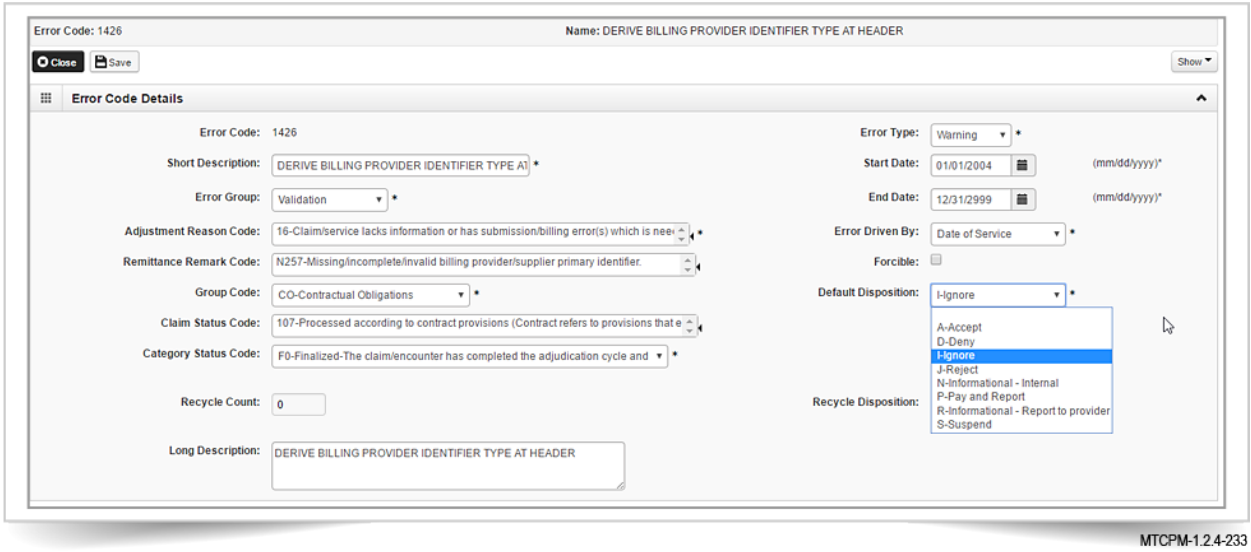


Figure 3.10.10-64. Error Code Details. The Error Code Details screen provides the user with a total picture of the error, including the error group, effective dates, long descriptions, and group error codes, among other information.

Once the review is complete, the claims processor determines the appropriate action to take on the claim. The options available at the top of the Resolve Claims List screen shown in Figure 3.10.10-65 are:

- Release: Release the claim, which sends it back through the adjudication process
- Refer: Allows the user to assign the claim to a specific individual for their review, such as a nurse or an operations coordinator for support
- Deny: Allows the user to deny the service line that set the error code

- Force: Allows the user to override and allow the service

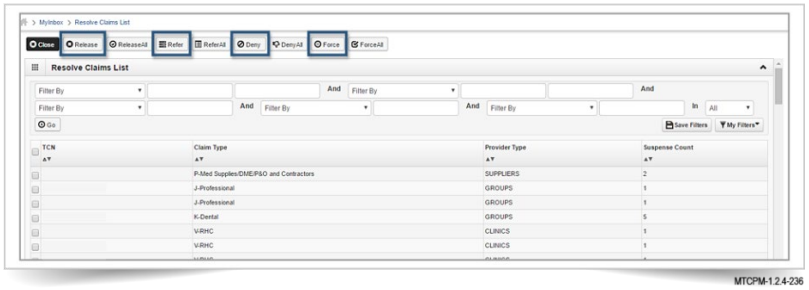


Figure 3.10.10-65. Resolve Actions on the Claims List. The claims processors use this screen to resolve the suspended claim by taking one of four actions.

Claims processors also have the ability to work on multiple claims, to resolve their suspended status, and then release all the claims at once through adjudication, using the "Release All" feature available to them on the screen, which will automatically reprocess suspended claims.

EPA49

The Contractor's solution shall adjudicate claims transactions against all identified member third-party payer benefits (e.g., primary, secondary, tertiary). The Contractor shall ensure all third-party payer benefits are exhausted prior to billing Medicaid.

Team CNSI's evoBrix X Core Claims module adjudicates claims transactions against all identified member third-party payer benefits (e.g., primary, secondary, tertiary). The solution ensures all third-party payer benefits are exhausted prior to billing Medicaid. Team CNSI's RuleIT rules engine has a pre-loaded library of extensive edits and Medicaid claims adjudication rules. These rules are invoked during claims adjudication and processed against member, claims, and TPL data received from multiple sources.

TPL validation is an integral component of the claims adjudication flow in the Team CNSI evoBrix X Core Claims module. Appropriate actions will be triggered based on the outcome of TPL validation, including:

- Denying claims when it is found that the member has active third-party coverage
- Deducting from the to be paid amount, the amount that the identified third party is liable to pay.

Figure 3.10.10-66 demonstrates if a member has other insurance and it's not reported on the claim, edit '1278 – Beneficiary has other insurance so provider must bill other insurance first' is set and the claim is denied.

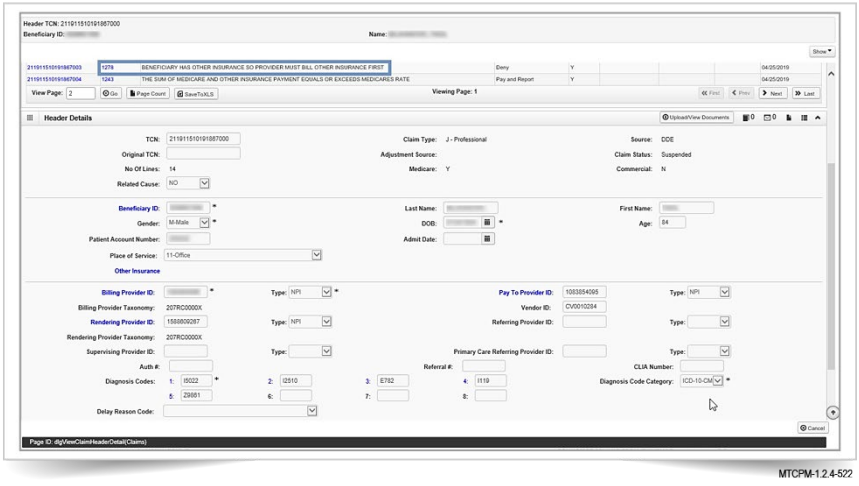
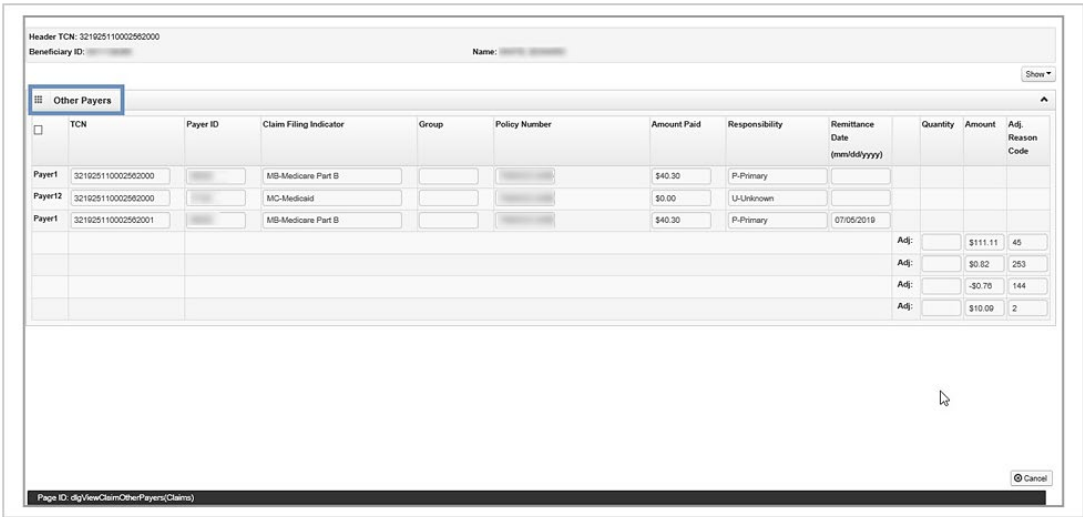


Figure 3.10.10-66: evoBrix X Core Claims Module's Claims Detail Screen with the Error Code. The evoBrix X Core Claims solution applies TPL edits.

EPA50

The Contractor's solution shall have the ability to create, receive, update, and store member Third Party Liability (TPL) information (e.g., primary, secondary, tertiary) as defined by the Agency.

Team CNSI's evoBrix X Core Claims module has capability to create, receive and update TPL information through screens and our solution provides robust features to process and manage third party payments, including a rich data store to support the flexibility needed to manage TPL. Figure 3.10.10-67 provides a sample screen from the application showing TPL information. In addition, evoBrix X CPMS has an extensive library of TPL edits that have been implemented in production in multiple states.



MTCPM-1.2.4-713

Figure 3.10.10-67. Member Third Party Liability (TPL) Information. Team CNSI's solution has the capability to create, receive and update TPL information through screens and our solution provides robust features to process and manage third party payments.

Third-party insurance details are maintained in evoBrix in a member-centric manner. Figure 3.10.10-68 describes the third-party insurance details that are stored in evoBrix and linked to the appropriate member.

Medicaid File	Match Made To:	Carrier File	Results of Match
Elizabeth	⟷	Liz	First name variation
J	⟷		Data absent in one file
Kramer	⟷	Kramer-Smith	Near match
123 Main St.	⟷	123 N. Main St.	Near match
Cheyenne	⟷	Cheyenne	Exact match
WY	⟷	WY	Exact match
82001	⟷	87023	ZIP code is different
307-442-2826	⟷	307-442-2827	Near match
2/22/1958	⟷	2/20/1958	Near match

iMatch correctly determines that these two records are for the same individual, despite several unequal data elements across eligibility files.

MTCPM-1.2.4-029

Figure 3.10.10-68. Third Party Insurance Details linked to Member ID. evoBrix has a robust TPL data store to support cost avoidance and recovery processes.

EPA51

The Contractor's solution shall support coordination of benefits pricing and editing when TPL sources such as Medicare, private, commercial, or other insurance is present, based on Agency configurable business rules.

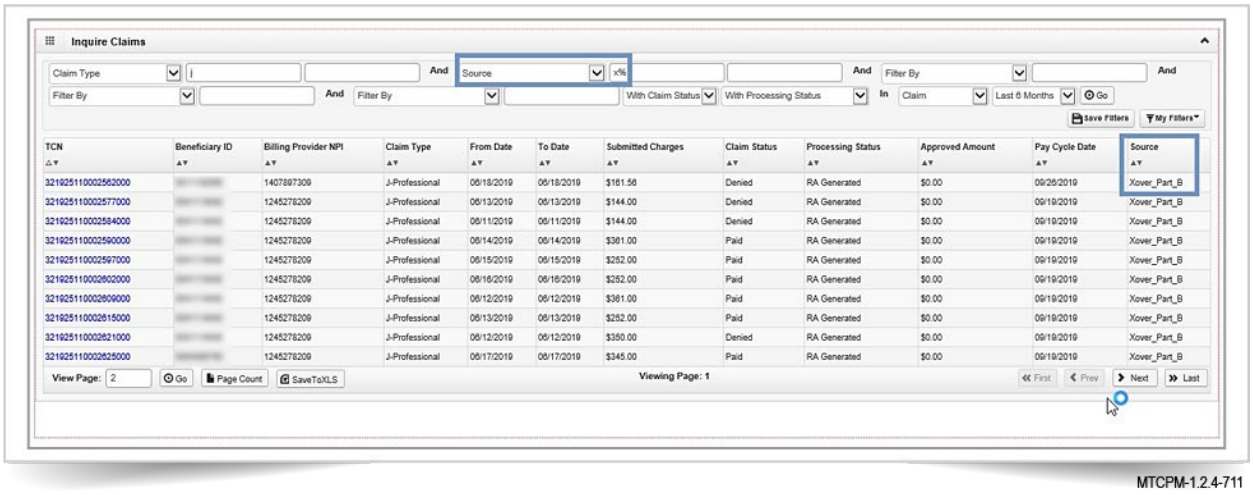
Team CNI's evoBrix X Core Claims module performs Coordination of Benefits (COB) pricing and editing when a member on a claim is found to have active third-party coverage (such as Medicare, private, commercial, or other insurance is present) when a claim is received. This includes:

- Generation and submission of an X12 837 to the third-party payer
- Deduction of the third party's liable amount when calculating the to be paid amount

The information received on the claim, along with the Reference and Member data available in the Core Claims module, is used to verify that all other payers have been accounted for before a claim is adjudicated and priced. This ensures that Medicaid is the payer of last resort.

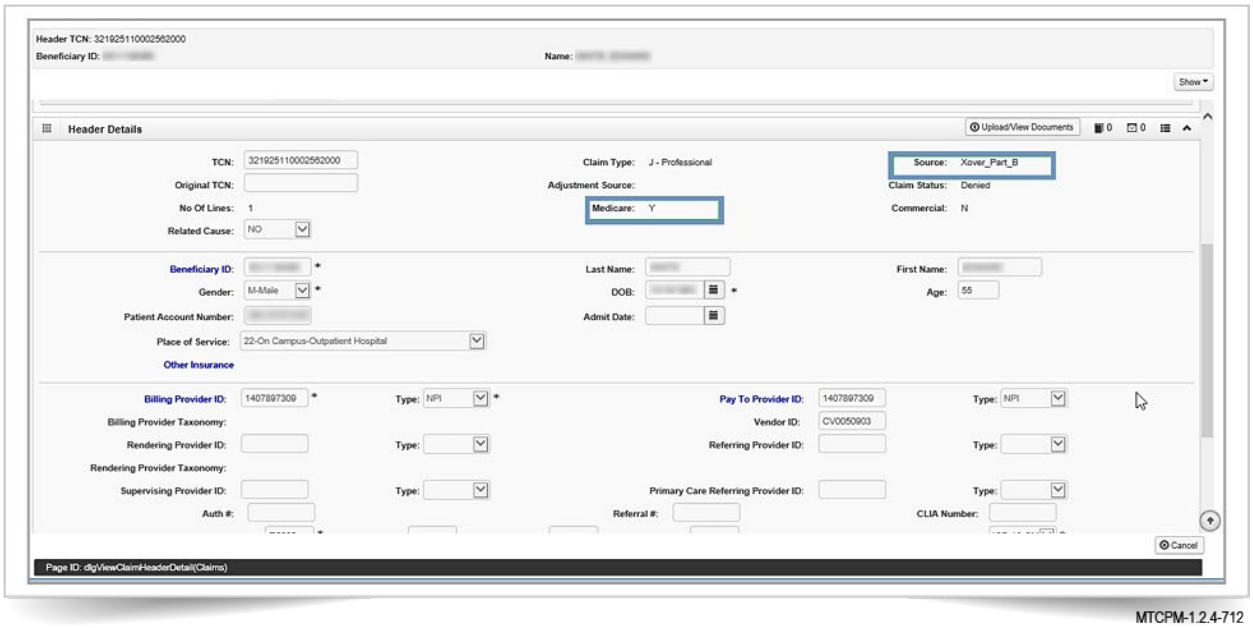
Receipt and processing of Medicare crossover claims are supported by the evoBrix X Core Claims module as shown in Figure 3.10.10-69 and Figure 3.10.10-70. Special rules are configured in RuleIT for the processing of these claims, which can be defined and/or customized to meet the needs of the Agency. This includes the logic to compute the Medicaid payment amount to be the lower of Medicare patient responsibility amount or the difference between the Medicare payment and the allowed Medicaid payment amount. The evoBrix X Core Claims module ensures that no amount will be paid on the claim if the Medicare paid amount exceeds the Medicaid allowable payment amount. This logic holds good for other third-party payers as well.

The evoBrix X Core Claims module is pre-built to process and reimburse a claim submitted to the Agency under Medicaid that is related to the same services claimed under Medicare and timely filed within a period of six months of receiving notice of the disposition of the Medicare claim. When there are multiple payers for a member in the TPL module based on coverage type, the provider is required to submit all other payer information on the claim as shown in Figure 3.10.10-71. If this is missing, the system posts an edit to the claim. The final disposition of the claim is based on the configuration of the edit. This ensures that Medicaid is the payer of last resort.



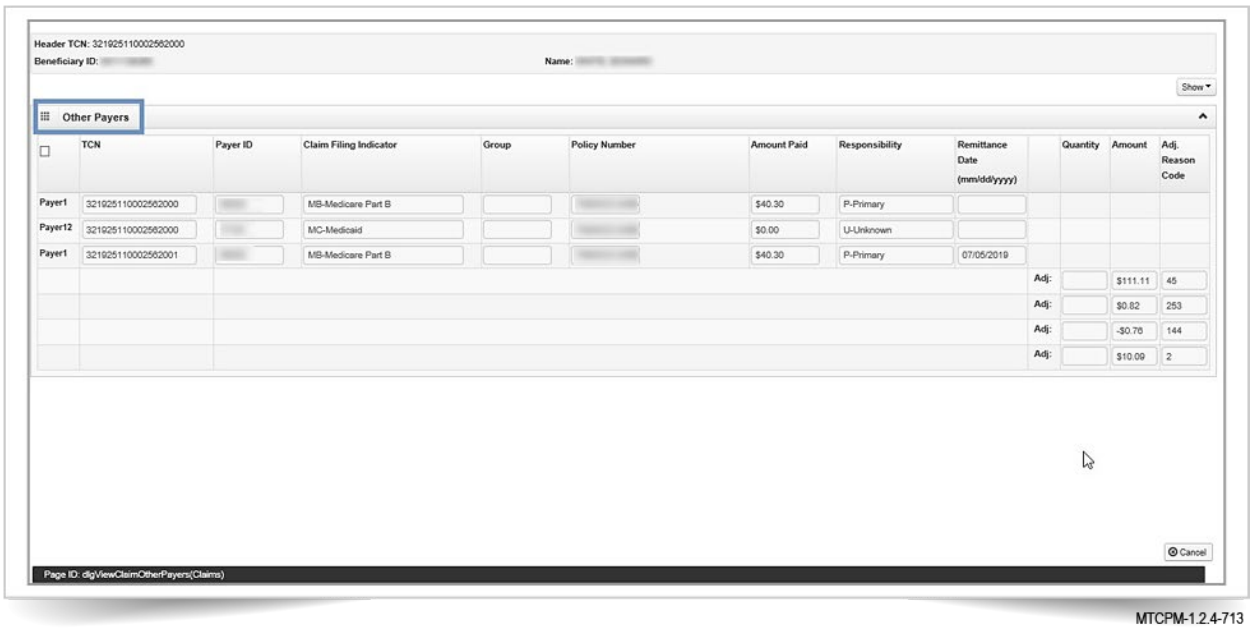
MTCPM-1.2.4-711

Figure 3.10.10-69. evoBrix X Core Claims module's Inquiry Screen. The Core Claims module offers a user-friendly interface to search on specific claims information. The screenshot above shows the claim search criteria for a crossover claim.



MTCPM-1.2.4-712

Figure 3.10.10-70. Claim Detail Screen Showing Source: X over Part_B and Medicare: Y. The solution accepts and processes crossover claims.



MTCPM-1.2.4-713

Figure 3.10.10-71. TPL Listing Viewed Online. Team CNSI's solution enables users to view other payer payment details associated with TPL Claims

EPA52

The Contractor's solution shall capture, track, maintain, store, and report claims processing and payment information based on configurable business rules (e.g. service category, provider type, submission date, entry date, claim input media, adjudication date, payment date) and Federal requirements as defined by the Agency

Team CNSI's solution provides a complete tracking and reporting of claims processing and payment information. The information is maintained in the evoBrix X CPMS and includes service category, provider type, submission date, entry date, claim input media, adjudication date and payment date. Team CNSI's evoBrix X CPMS solution will process and pay claims accurately within State and Federally required timeframes, excluding days assigned to Agency staff. The solution provides claims information based on the below criteria and as shown in Figure 3.10.10-72.

- Provider Type.
- Claim submission date.
- Claims entry date.
- Claim input media (i.e., paper, HIPAA, or DDE).
- Claims processing date.
- Payment date.

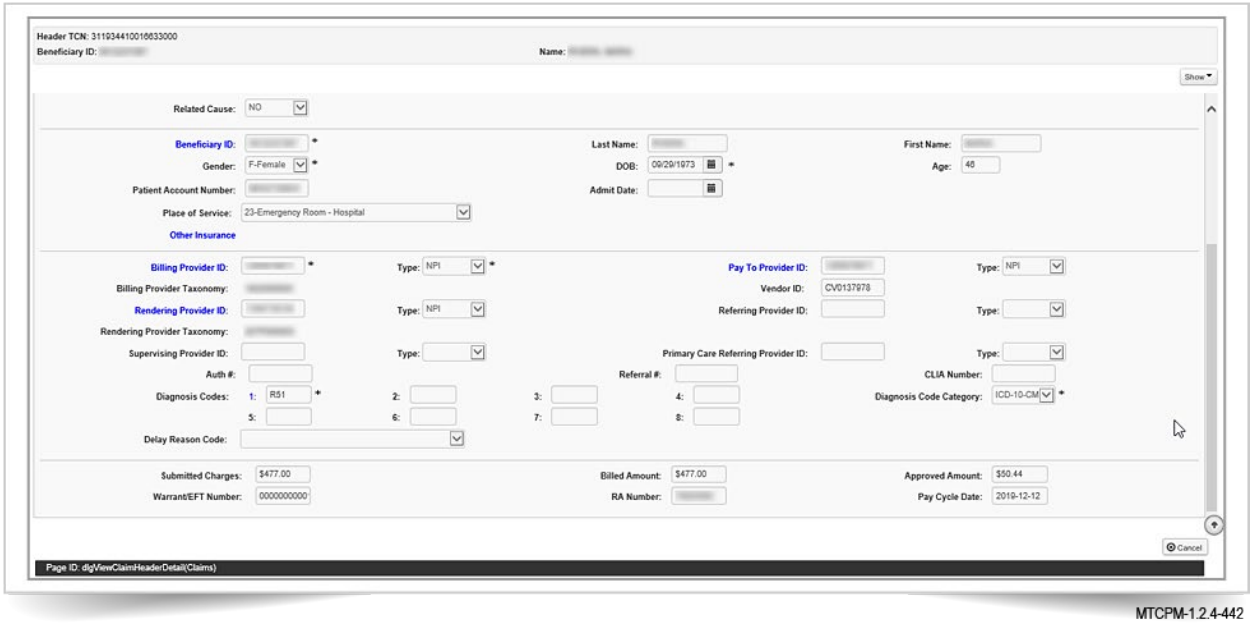


Figure 3.10.10-72. Claim Details Screen. The holistic view of charges and claims payments on evoBrix screen.

EPA53

The Contractor's solution shall capture, track, maintain, store, and report claims processing and payment information based on configurable business rules (e.g. service category, provider type, submission date, entry date, claim input media, adjudication date, payment date) to validate requirements contained in 42 CFR 447.45.

Team CNSI's solution enables the State to be in compliance with 42 CFR 447.45 and timely claims payment, by maintaining the necessary data to support the compliance. Team CNSI's solution provides

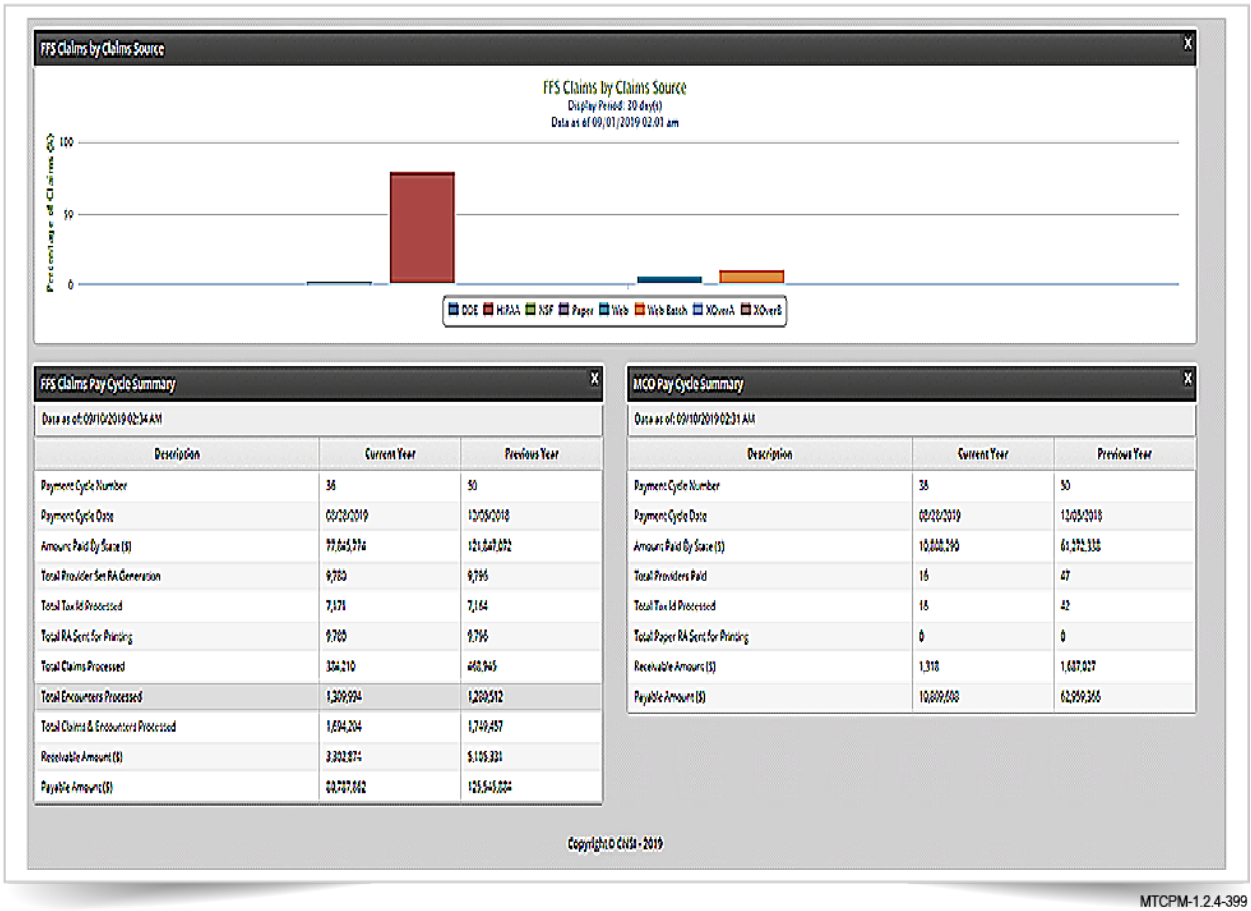
complete tracking and reporting of claims process and payment information by service category or provider type. Reports will be provided to the Agency to support this requirement. HealthBeat® will also be configured to provide this information on a near-real time basis as shown in Figure 3.10.10-73, Figure 3.10.10-73, Figure 3.10.10-74, and Figure 3.10.10-75. The combination of reports and HealthBeat® enable the Agency to analyze timely processing compliance as per 42 CFR 447.45. HealthBeat® solution also comes with automatic notification feature which sends an alert to appropriate team when a business process exceeds the set threshold. The thresholds can be configured for each business process. Timely alerts trigger prompt actions by operations staff, enabling them to avoid potential backlogs throughout the claim life cycle as shown in Figure 3.10.10-76. Our solution provides a holistic view of claims operations through HealthBeat to ensure accurate reporting and alignment with SLAs.



Figure 3.10.10-73. HealthBeat® Operations Dashboard for Claims related Matrices with Compliance and Claims Aging graphs. Team CNSI's HealthBeat® enables the Agency to view operations data in near real-time.

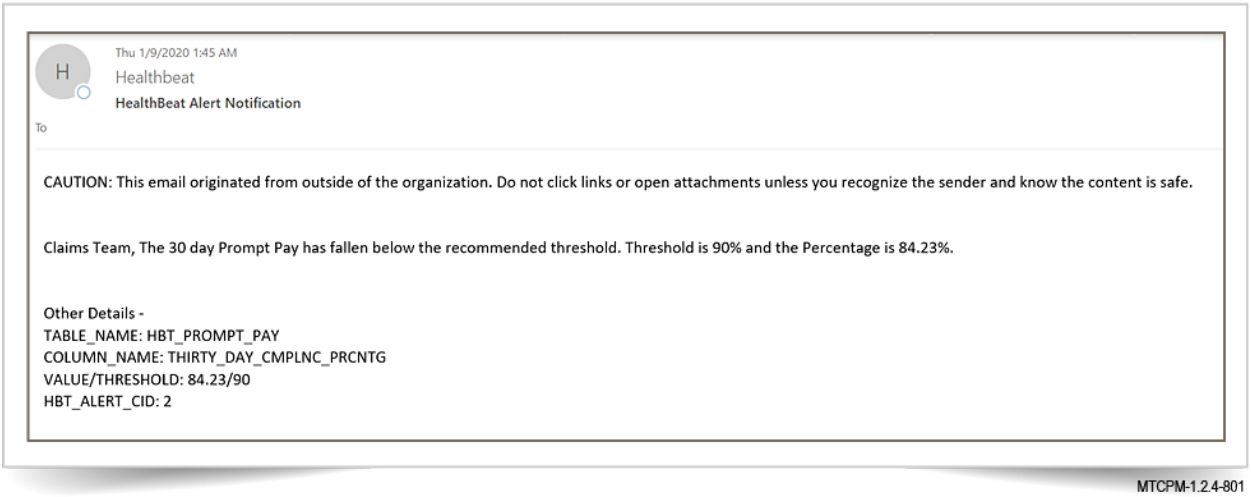


Figure 3.10.10-74. HealthBeat Operations Dashboard. HealthBeat has the ability to display claims payment information by pay cycles to provide continual operational insight.



MTCPM-1.2.4-399

Figure 3.10.10-75. HealthBeat Metrics Details. HealthBeat Operations Dashboard for Pay Cycle Summary



MTCPM-1.2.4-801

Figure 3.10.10-76. HealthBeat Business Operations Alerts. Sample alert generated by HealthBeat® when the Prompt Pay fall below the threshold.

EPA54

The Contactor's solution shall adjudicate claims transactions and edit against provider enrollment status based on Agency defined configurable business rules.

Team CNSI's evoBrix X Core Claims solution includes provider business status verification, a feature which ensures the provider will not be paid if they are not active or valid. At the core of the adjudication process is RuleIT, Team CNSI's rules engine, which contains rules for editing and pricing that are required to appropriately adjudicate a claim. Our claims adjudication process applies edit and audit rules for all modules within the system. During this process, edit rules are executed in sequence before a final decision is made on the claim.

Figure 3.10.10-77 explains the evoBrix X Core Claims solution adjudicates claims transactions and edit against provider's enrollment status

Edit	Description
Edit 1130	Submitter Not Active on Claim DOS If a submitting provider is not active on a claim submission date, then post edit at header level.
Edit 1094	Rendering Provider Not Entered Professional and Dental Invoice - If Billing Provider Enrollment Type is equal to '2' and if Line Servicing Provider is not present, then post the edit at line.

Figure 3.10.10-77. Claims Edit Categories. The evoBrix X Core Claims Solution edits are configurable to enable the system to readily support changing business rules.

Our solution normally denies payment for claims submitted by providers who are not found to be in an active enrollment status with the Agency. Suspension of claim payment for providers who are in the midst of the enrollment process will be configured as a new rule in RuleIT.

EPA55

The Contactor's solution shall identify all claims in the adjudication cycle by billing provider, group by claim status (e.g., paid, denied, suspended, adjusted) and generate a remittance or downloadable remittance using a current or future HIPAA standard format following CAQH core operating rules.

The evoBrix X Core Claims solution identifies all claims in the adjudication cycle by billing provider. group by claim status (e.g., paid, denied and adjusted) and generates a remittance or downloadable remittance using a current or future HIPAA standard format following CAQH core operating rules.

Team CNSI's evoBrix X Core Claims solution can be configured to group by 'suspend' claim status while generating remittance advice. Whenever a new HIPAA X12 standard format is mandated, Team CNSI will conduct collaboration sessions with State team and finalize the release schedule. Based on the new rules, Team CNSI will customize the evoBrix X Claims module to accommodate the new standard.

The evoBrix X Core Claims module updates all the claim documents with the appropriate check or EFT information received from the State Auditor's Office (SAO). Once this is complete, the evoBrix X Core Claims module generates the remittance advice (RA) in PDF format to mail it to the providers. The Core Claims module also generates a HIPAA payment transaction (i.e., HIPAA 835) file to transmit. These paper RAs and HIPAA 835 files contain the payment information and associated paid claims, voids, payment adjustments, and denied claims.

The RA documents are archived and made available to providers through the provider portal and to State staff through the evoBrix X Core Claims screens (via the web) as shown in Figure 3.10.10-78. Clicking on '835' in the top right, opens the Remittance Advice that is downloadable.

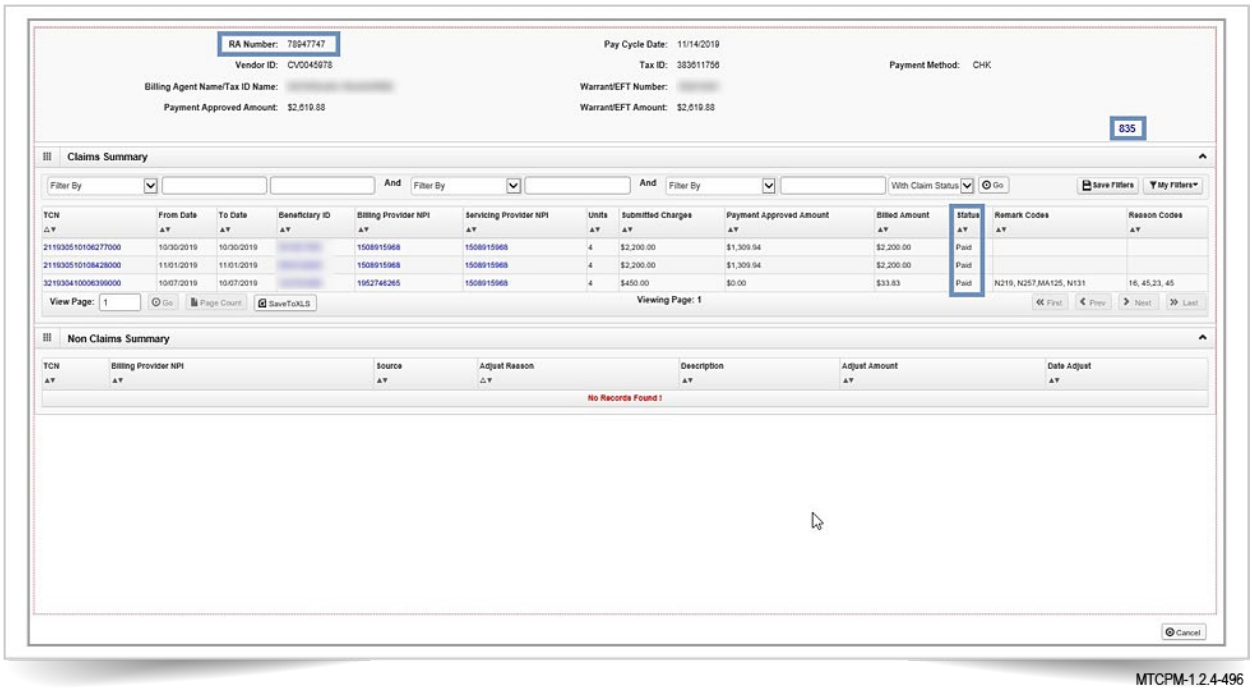


Figure 3.10.10-78. evoBrix X Core Claims Screen. The Core Claims module provides the option to view the claims associated to a Remittance Advice.

EPA56

The Contractor's solution shall have the ability to automatically and/or manually configure an edit to process claims or adjustments for a specific event (e.g., retroactive rate adjustment) or group of claims (e.g., edit, batch, provider type, member, claim type) as defined by the Agency.

Team CNSI's solution triggers any course of action based on a particular event for original or adjudgment claim transaction as defined by DPHHS. Edits can be configured to be triggered for a specific claim type, providers, member, or a batch of claims transaction for retroactive rate adjustments. Edits are created and maintained in Team CNSI's RuleIT rules engine, one of the core components of our solution. The data-driven architecture of Team CNSI's solution, in combination with RuleIT, allows us to change functionality without making any code modifications. Configurable data tables, part of the evoBrix X Core Claims module, are used in conjunction with RuleIT to maximize flexibility.

Mass Adjustment functionality provides the capability to perform bulk actions such as adjusting claim transactions for retroactive rate adjustments. Team CNSI has a highly automated solution and mature business operations processes to perform mass adjustments. Team CNSI's operations staff uses the evoBrix X Core Claims module's mass adjustment screen to enter criteria to identify the claims that need to be adjusted. The system has a range of options within the criteria fields that is made available to the claims processor for mass adjustment.

Operations staff can enter up to five different selection criteria from the various available options before submitting the request. Specific claims can also be directly selected for the mass adjustment process by operations staff without having to enter the selection criteria. After the selection criteria is entered on the

mass adjustment screen, operations staff can submit the request. The evoBrix X CMPS background processes keep polling the adjudication queue at regular intervals to look for claims for adjudication.

Our business operations staff, who submitted the mass adjustment request, reviews the adjusted claim's business status of pending, paid, or denied against the original claim. They compare the dollar amounts and other details, such as the benefit group number relevant to the claim, to ensure that the claim was processed as expected. When the results are in line with what was expected, the claims processor submits the mass adjustment batch to another claims processor for a second review. All of these activities are automated using the mass adjustment functionality within the evoBrix X Core Claims module.

EPA57

The Contractor's web portal real-time direct data entry claims solution shall support the creation and maintenance of provider type specific claim templates for recurring billing (i.e., roster billing to allow institutional or residential service providers to create a template with multiple members for monthly billing, enter patient days, generate and submit claims, recall the template, add or remove members or service authorization numbers, and generate claims for the next month, recall a specific claim from the template for adjustment/void) and provide notification to the provider via secure inbox if a template is not regenerated within a timeframe defined by the Agency.

Team CNSI's evoBrix X Core Claims module provides the capability to create and maintain specific claim templates that is built to remove the labor-intensive task of re-entering the same data on similar claims. We provide a claim template feature enabling providers to save reusable claims data as a template. The saved claim templates can be searched, as shown in Figure 3.10.10-79, using various options. The Search Template feature allows users to get the most appropriate template to speed up the data entry work.

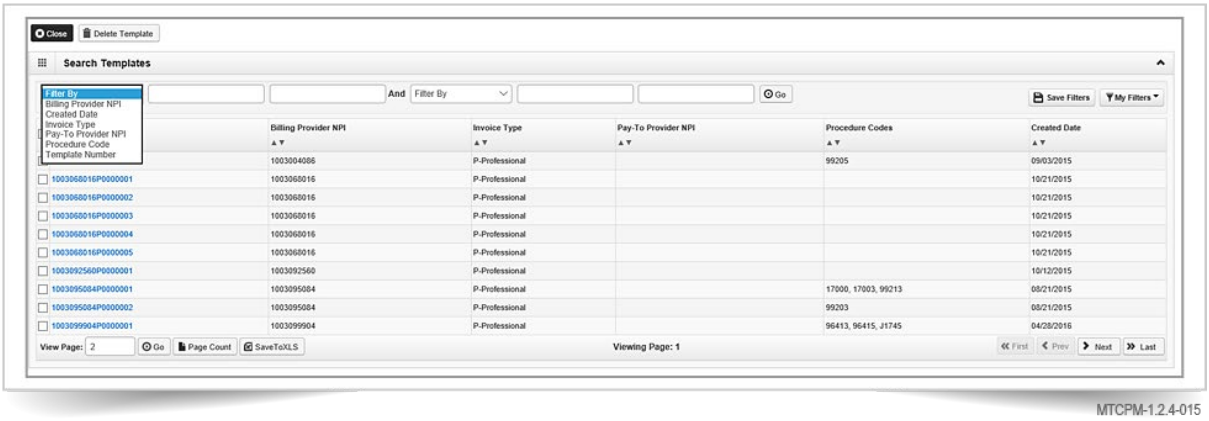


Figure 3.10.10-79. Search Templates. Saved templates help providers and claims staff to quickly select an appropriate template to enter a claim.

Team CNSI's evoBrix X Core Claims solution supports:

- Roster billing to allow institutional providers to create a template. The same template can used to submit different claims for different members. For an institutional claim, patient days can be saved as part of the template.
- Recalling the template – a template can be configured to recall and used to submit new claims
- Generation and submission claims - Using these templates, Providers can submit claims as shown in the Figure 3.10.10-80.

The system will be customized to meet the following business requirements based on the agreed solution in the collaboration sessions:

- Adding or removing members or service authorization numbers
- Generating claims for the next month
- Recall a specific claim from the template for adjustment/void
- Provide notification to the provider via secure inbox if a template is not regenerated within a timeframe defined by the State.

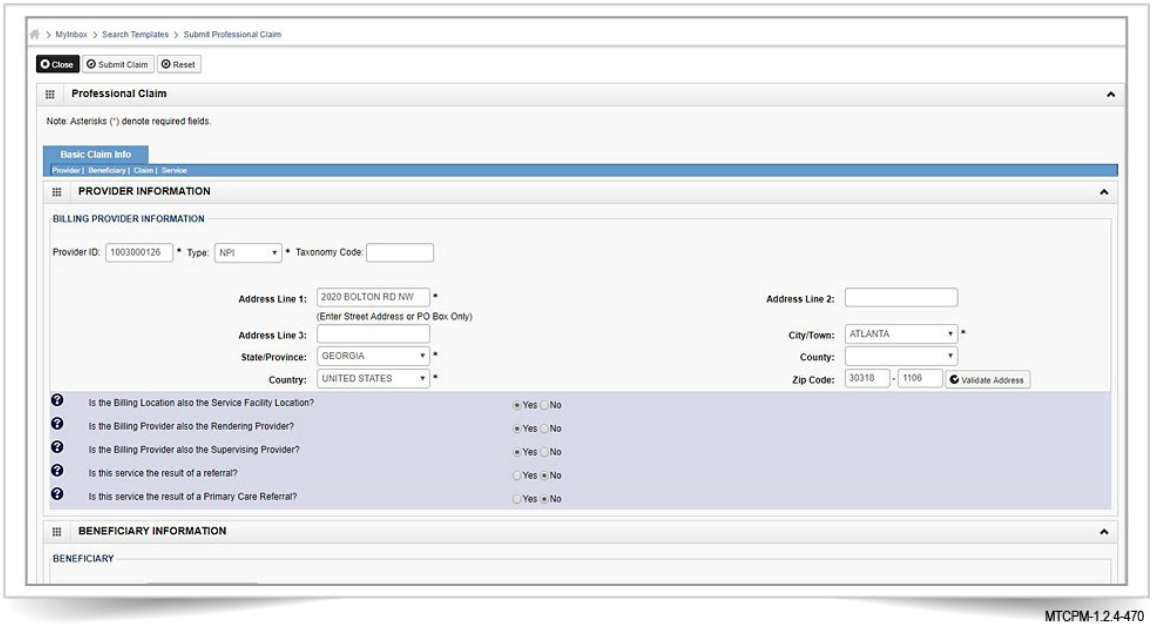


Figure 3.10.10-80. Submit Claims using Templates. When a template is selected to enter a claim, the screen above is displayed.

EPA58

The Contractor's solution shall assign each claims transaction, adjustment, and void a unique identification number (i.e. ICN or TCN). The unique ID must be assigned to each claim and associated attachment prior to adjudication.

As a part of Team CNSI's evoBrix X Core Claims module, every claim entering the system through any source (i.e., DDE, EDI, paper, or file upload) is assigned a unique TCN, which is used to track and maintain a claim throughout the adjudication process. This unique transaction control number (TCN) is assigned to each claim, adjustment, void or piece of correspondence attached. The TCN identifier assigned to the document is the means of both retrieving the document and related documentation to allow for processing and status reporting throughout the claim life cycle. Attachments receive the same unique identifier as the primary document to allow all related documents to be retrieved as a unit. TCNs are assigned in several places throughout the system including:

- Claims OCR
- Claims DDE Screens
- HIPAA Loading Processes that load electronically submitted batches of Claims and Encounters
- Adjustments
- Gross Adjustments
- Voids
- Recurring Payments

When a TCN is assigned to a Claim, the first two characters in the TCN Input Medium Indicator and TCN Category are set by the System. When a claim is submitted to the Claims Adjudication process, the TCN

is either generated by the source subsystem, or it is generated as a part of the Claims loading process. The TCN shows the actual business date of receipt, record type, batch number, and sequence number. The table below displays the taxonomy of the Transaction Control Number (TCN).

Figure 3.10.10-81. Transaction Control Number Composition. Every claim entering the system through any source is assigned a unique TCN and it is used to track and maintain a claim throughout the adjudication process.

Field	Length	Type	Description
Input Medium Indicator	1	Numeric	0 – Reserved 1 – Paper - Assigned by the Imaging System when the Claim is received in paper format. 2 – Direct Data Entry (DDE) (Web Submission) - Assigned by the System when the Claim is submitted through the DDE Screens 3 – Electronic (HIPAA) - Assigned by the System when the Claim or Encounter is submitted as an electronic batch. 4 – CE System-generated - Assigned by the System when the transaction is generated by the Claims Subsystem. 5 – CM System-generated - Assigned by the System when the transaction is generated by the Contracts Management Subsystem. 6-7 – Reserved 8 – Paper – With Attachments 9 – Reserved
TCN Category	1	Numeric	0 – Reserved 1 – FFS - Assigned to any claim that is submitted directly to the System including Institutional, Professional and Dental Claims. 2 – Crossover – Assigned to any Claim received from GHI – the national Medicare intermediary. 3 – Encounters - Assigned by the loading routine when the indicator on the X12 Claim is set as an Encounter including Institutional, Professional and Dental. 4 – Capitation Claims – System-generated claims created by the Contracts Management Subsystem. 5 – Gross Adjustments – System-generated by Claims and Contracts Management Subsystems. 6 – Pharmacy Encounters – Stored and assigned TCN in the Data Warehouse. Not available in CHAMPS. 7 – Recurring Payments – System-generated by Claims and Contracts Management Subsystems. 8-9 – Reserved
Batch Date	5	Numeric	YYDDD – Year + 3-digit Julian date.
Adjustment Indicator	1	Numeric	1 – Original Claim 7 – Replacement Claim 8 – Void All valid NUBC frequency type codes are mapped to one of these values for internal processing (Patrick – add appendix for mapping).
Sequence Number	7	Numeric	By input medium, starting with 0000001 at the beginning of each Julian date.
Line Number	3	Numeric	Line Number will begin with 001 for every new Claim. The header will have the line number as 000.

Figure 3.10.10-81. Transaction Control Number Composition. Every claim entering the system through any source is assigned a unique TCN and it is used to track and maintain a claim throughout the adjudication process.

EPA59

The Contractor's solution shall process claims adjustments and voids; maintain the original claim and link all adjustments and voids to allow users to easily view the claim processing history as defined by the Agency.

Team CNSI's CPMS will retain claims per DPHHS policy and guidelines so that adjustments can be made and include claim detail such as who changed the claim, why it was changed, and what was changed, as shown in Figure 3.10.10-82. Team CNSI's CPMS is configured to identify history-only recoveries and payments. It is pre-built to process void and adjustment requests of previously paid claims. The system retains the claims information per DPHHS policy and guidelines and supports mass and individual adjustment and void requests. Further, it tracks the user who has initiated the change request, the adjustment reason submitted, and the data being changed in the claim(s).

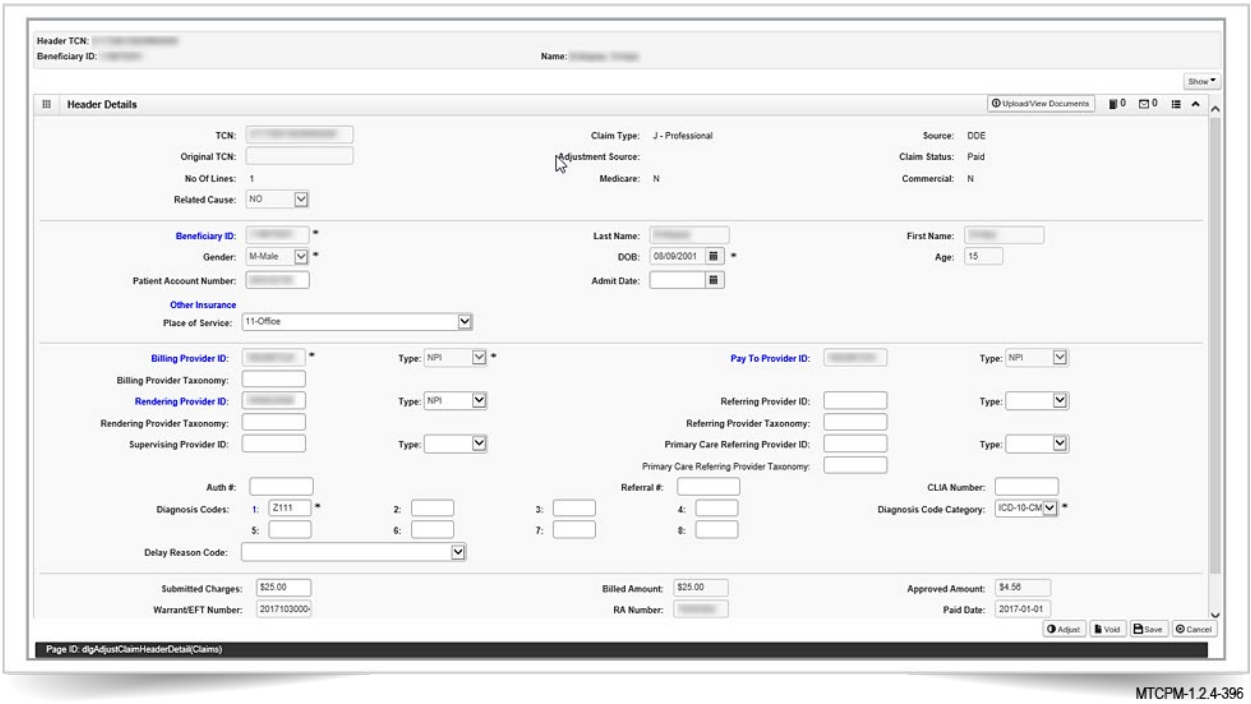
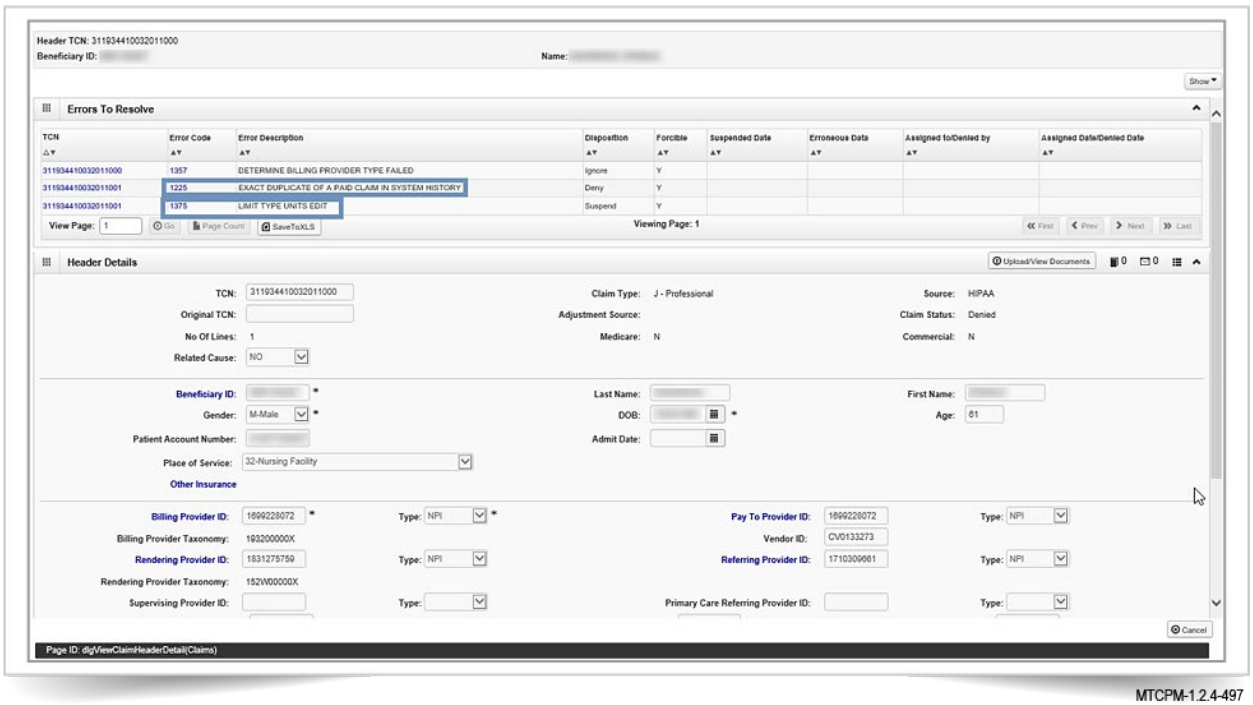


Figure 3.10.10-82. Adjust or Void Claims. Agency staff can adjustment or void the claims through adjustment screen.

EPA60

The Contractor's solution shall have the ability to edit new claims against prior history of adjudicated and in-process claims (e.g., once in a lifetime service limits, cumulative limits, duplicates) using Agency's defined configurable business rules.

Team CNSI's evoBrix X Core Claims module edits new claims against previously adjudicated and in-process claims (e.g., once in a lifetime service limits, cumulative limits, duplicates) using configurable business rules. As shown in Figure 3.10.10-83, the evoBrix X Core Claims module applies edit '1375 – Limit Type Units Edit' to ensure that claims do not exceed their benefit limit units or dollars. It also applies edit '1225 – Exact Duplicate of a Paid Claim in System History' after performing a duplicate check.



MTCPM-1.2.4-497

Figure 3.10.10-83. evoBrix X Core Claims Claims Detail Screen with the Error Code. The evoBrix X Core Claims solution applies limits and duplicate edits.

Limits: The solution applies claims edits to ensure that claims do not exceed their benefit limit units or dollars. Criteria for service limits are configurable in the Reference module and can be established to cover various time periods: month, year, or lifetime. Limits, limit associations, and conflict criteria can be defined using the Reference module, which our solution utilizes during claims adjudication. Three types of limits are available for configuration as follows:

- Dollar Limits provide a means of specifying services that have a cap on the dollar amount for a member over a given period of time.
- Units Type Limits provide a means of specifying services that have a cap on unit amounts for a member over a given period of time.
- Conflict Type Limits provide a means of specifying conflicting services, which should not be performed on the member based on the given criteria.

Exceptions to limits are defined in RuleIT. The system denies or suspends a claim for a history audit. The suspended claim is then made available for analysis by our resolution staff. Having both the current and conflicting history claim available saves time when a provider inquires on such denials, and generally results in a more satisfying outcome for the provider. The evoBrix X Core Claims module handles service limitations by configured limit definition. Limits are established with a combination of factors that can be configured to establish appropriate limit verification. These factors can include various periods, including lifetime, year, month, state or federal fiscal year, or school year. Limits can be set up for units or dollars with the same provider, any provider, or servicing provider. Once a member utilizes all units or dollar amounts defined for a service, the claim adjudication process posts the edit.

Duplicates: The evoBrix X Core Claims module uses claims history information and current claims data when performing duplicate check logic. Our solution provides functionality for our claims staff to define "exact duplicate" and "suspect duplicate" edit criteria and allows users to manage duplicate criteria through online screens, as shown in Figure 3.10.10-84. After checking for a duplicate claim, our solution determines whether a current claim is an exact or suspect duplicate of a previously paid claim. Upon

finding a "paid" or to be paid" claim, our adjudication engine references the defined criteria to post edits where the configured elements are matching.

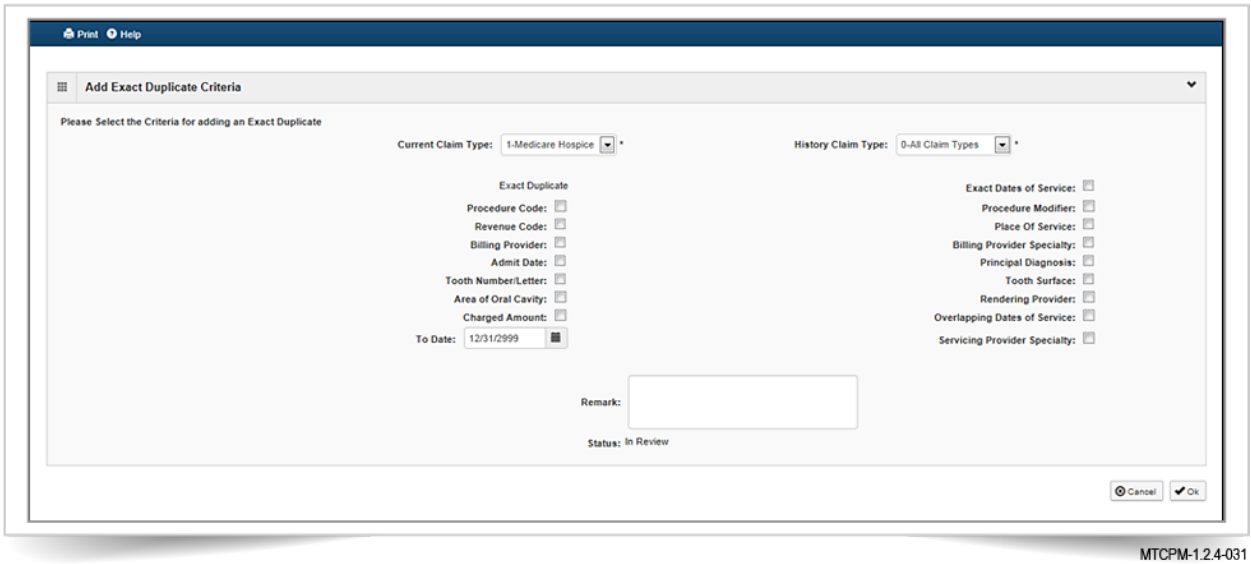


Figure 3.10.10-84. Audits Supporting Duplicate Checks. Team CNSI's solution provides the capability to define exact duplicate criteria based on claim attributes.

EPA61

The Contractor's solution shall, in the absence of required information (i.e. missing attachment) and after multiple adjudication cycles over a timeframe defined by Agency, auto-deny the edit and process the claim.

Team CNSI's evoBrix X CPMS provides multiple options for providers to submit documents to support the claims adjudication process. With the use of an upload attachment functionality, authorized users can upload the documents using the web portal screens and have the flexibility to retrieve the attachment to perform their work functions. The evoBrix X Core Claims module allows edit processing to consider the existence of attachments sent by the submitter as part of a business rule. When an edit determines that the service requires additional documentation and the claim does not indicate the documentation has been received, Correspondence API is used to generate letters to providers identifying the need for additional documentation and the system automatically sends an online reminder to the billing provider's inbox notifying the provider of the need for additional information to process the claim. This notice will appear the next time the provider logs into the system. Team CNSI has significantly shortened the response time to process the attachments received, for claims that are suspended in the Core Claims module. If the attachment is received, the claim is suspended for manual review of the attachment. If the attachment is not received within a pre-defined timeframe, then the adjudication cycle will auto-deny the claim. Figure 3.10.10-85 shows the screen where documents can be uploaded.

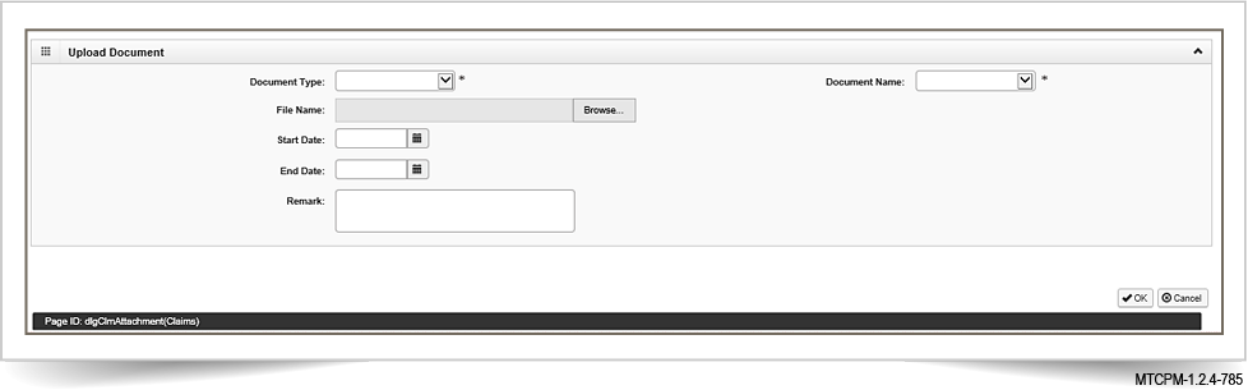


Figure 3.10.10-85. evoBrix X Document Repository. The upload document screen is used to attach documents to a claim.

EPA62

The Contractor's solution shall have the ability for users to manually route suspended claims to work queues based on Agency defined business rules.

Team CNSI's solution enables claims to be suspended when the underlying business conditions are met. The workflow engine will be configured to the assign a default workgroup when a claim is suspended with edits. The users of the workgroup can further route a suspended claim to a different user further investigation as shown in Figure 3.10.10-86.

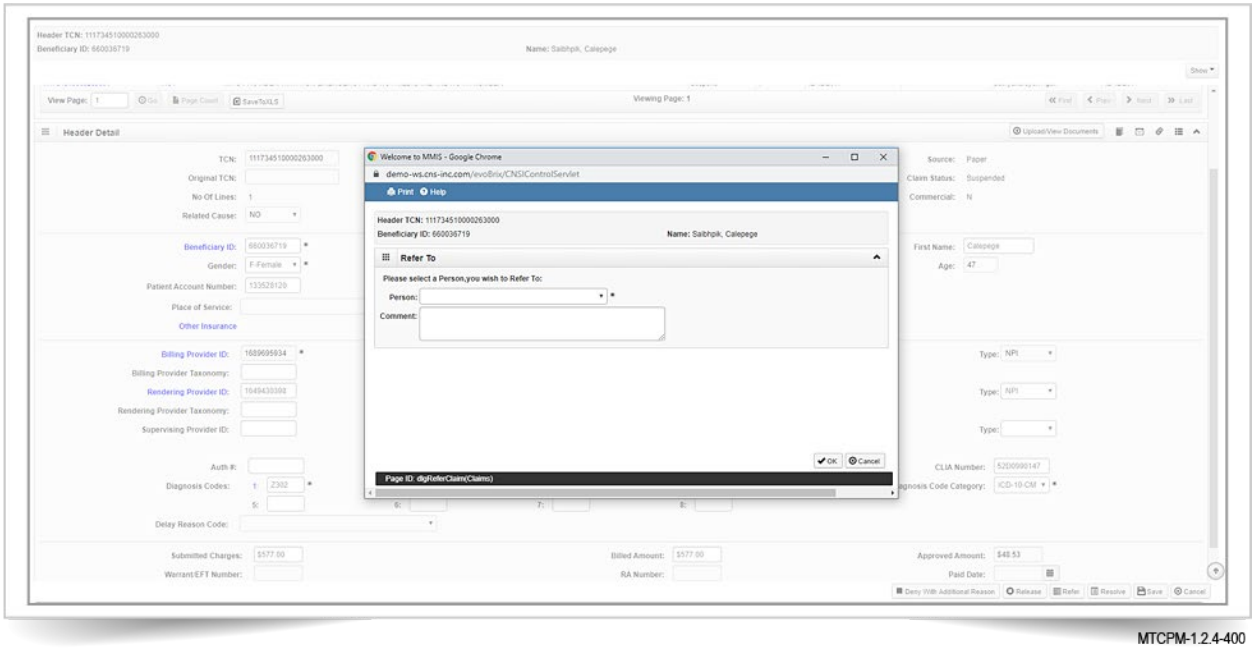


Figure 3.10.10-86. Manual Routing of Claims. evoBrix X Core Claims module provides an option to refer a claim to a different user.

EPA63

The Contractor's solution shall have the ability to automatically route suspended claims to work queues based on Agency defined business rules.

The solution comes with an integrated workflow engine to manage the workflow for multiple business and operational processes. Team CNSI's evoBrix X Core Claims module supports workflow-based capabilities for multiple business and operational processes. The workflow is driven by defining business conditions and assignment rules. It also includes the ability to define user groups to which the tasks are routed. The solution can be configured to trigger any course of action based on a particular event. This includes a course of action that routes all suspended claims (except those that require Agency review) for manual resolution.

EPA64

The Contractor's solution shall create, maintain, store, and display a configurable crosswalk (e.g., procedure codes, diagnosis codes, benefit plans) to define valid/invalid combinations as defined by Agency.

Provider and reference data validation is an integral component of the claim's adjudication flow in Team CNSI's evoBrix X Core Claims module. The Core Claims module creates, maintains, stores, and displays a configurable crosswalk (e.g., procedure codes, diagnosis codes, benefit plans) to define valid/invalid combinations as defined by the State. Figure 3.10.10-87 provides the configurable crosswalk and the RuleIT edits for valid/invalid combinations business rules.

Edit Number	Description	Posting Logic
1140	DENTAL TOOTH NUMBER OR LETTER MISSING OR INVALID	Dental Invoice - If Procedure Tooth Number Required Indicator is "Y" and Tooth Number is Empty then post error for Line.
1141	DENTAL TOOTH SURFACE MISSING	Dental Invoice - If Tooth Surface Required Indicator is "Y" and if the Tooth surface is either empty or 0 then post edit for Line.
1142	PROCEDURE OR REVENUE CODE NOT COVERED BY MDCH ON DATE OF SERVICE	1.If Procedure Code is present and Procedure Medicaid Covered Indicator is equal to 'N' then post edit for line. 2.If Revenue Code is present and Revenue Medicaid Covered Indicator is equal to 'N' then post edit for line.

Figure 3.10.10-87. Edits Crosswalk. evoBrix X solution maintains the configurable crosswalk of RuleIT business rules' valid/invalid combinations

One of its purposes is to validate claim service data against the relevant benefit plan data present in the solution database. Several categories of benefit plan data are looked up, including the following:

- Coverage under benefit plan
- Type of provider
- Procedure/service
- Co-pay
- Taxonomy
- Diagnosis

The solution has pre-configured rules flow, which will be configured to support the rules requirements. The Core Claims module provides the flexibility to maintain reference data combinations and build

specific pricing decision matrices. Using the application screens, Team CNSI maintains code sets, limits, modifiers, place of service, and rates as shown in Figure 3.10.10-88.

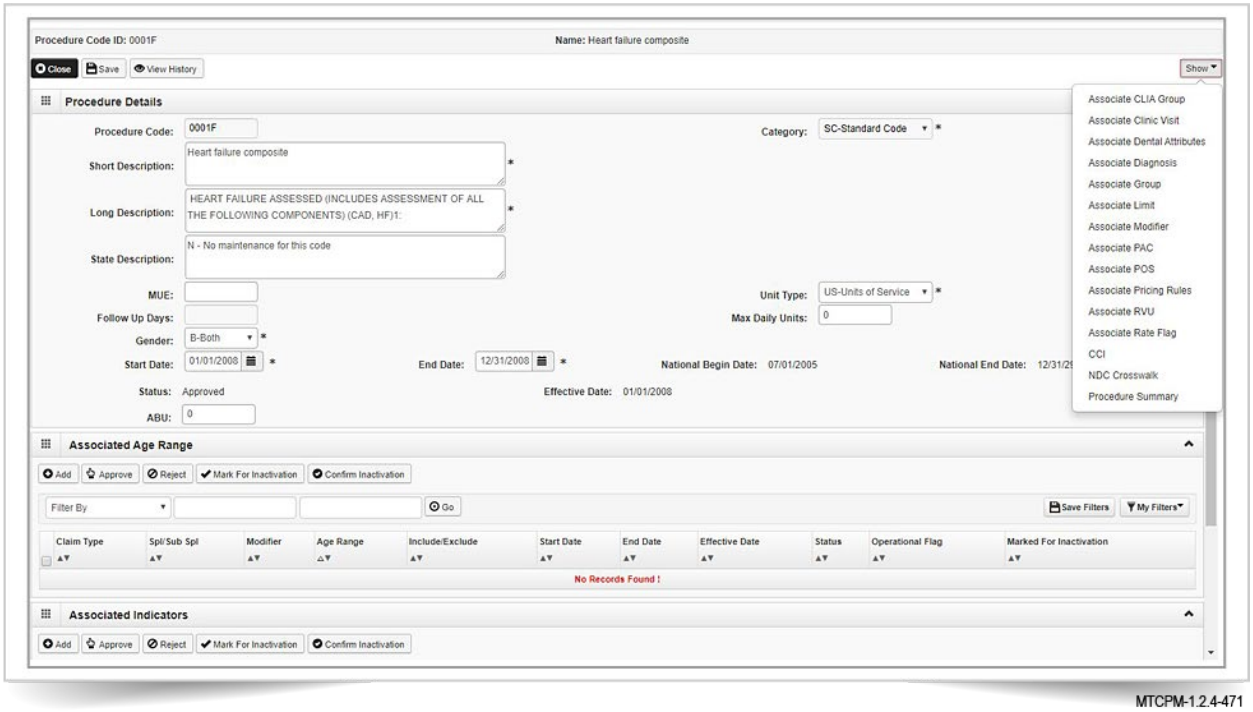


Figure 3.10.10-88. Reference Data Maintenance. evoBrix X solution maintains Reference Data information such as Procedure Codes along with associated Diagnosis Codes, Limits, Pricing Rules and more.

This ensures that all claims are priced per the benefits, provider contracts, and reimbursement methodologies laid out by the State's policy. Team CNSI's solution pricing logic is well-articulated and maintained diligently using structured documentation practices, supported by exhibits to explain the payment methodology.

EPA65

The Contractor's solution shall allow for a configurable edit disposition (i.e., retain all, none, or selected prior edit dispositions) on a claim adjustment (e.g., mass adjustment, individual claim adjustment) to finalized claims.

Edits are created and maintained in Team CNSI's RuleIT rules engine, one of the core components of our solution. Disposition controls how an edit is handled by the system during claims adjudication when determining the claim status. Error code dispositions are configured based on the claim category (e.g., DDE, paper, system generated, replacement) and claim type (e.g., Inpatient, Outpatient, Nursing Facility). This functionality is especially helpful for defining new edits. For example, the Agency may choose to set up an edit to suspend claims for a period of time, to evaluate how it is posting, prior to setting up the same edit to automatically deny claims. The evoBrix X Core Claims module supports six dispositions: Paid, Denied, Informational, Pay and Report, Suspend, and Ignore and can be easily extended to configured additional disposition codes as needed by the Agency.

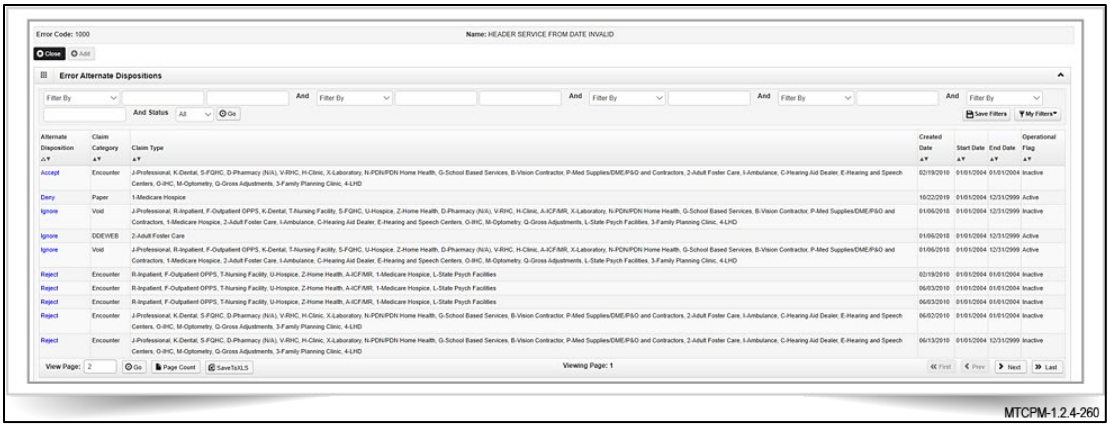


Figure 3.10.10-89. Error Alternate Dispositions. Using the Error Alternate Dispositions, evoBrix X posts edit disposition on a claim adjustment.

DPHHS will realize the following benefits with RuleIT:

- Empowered business users. RuleIT provides a configuration-driven approach and acts as a centralized business rules repository, enabling business users to maintain business rules easily.
- Faster implementation. RuleIT is packaged with a pre-built healthcare dictionary and edit rules to facilitate faster implementation. Employing a run-time caching mechanism for improved performance, RuleIT contains rules that are logical statements consisting of conditions.
- English-like syntax. The RuleIT Composer provides the ability to create, edit, and maintain business rules in an English-like language. The RuleIT Processor is the run-time engine that is used during claim adjudication.
- Easy claims configuration and editing. RuleIT provides users with the ability to understand, interpret, modify, and create new claims adjudication rules. New edits can be configured without changing the underlying application code.

The data-driven architecture of Team CNSI's BMS solution, in combination with RuleIT, allows us to change functionality without making any code modifications. Configurable data tables, part of the evoBrix X Core Claims module, are used in conjunction with RuleIT to maximize flexibility within evoBrix X. evoBrix X also provides screens and tools to allow authorized users to add and modify these data sets. At every step of the adjudication process, business logic is executed, and any violation captured via error codes as follows:

- Error codes document rule violations and provide a description of the issues the claim has encountered.
- Error codes are mapped to standard CARC, RARC, and CAGC.
- Properties are attached to an error code, including "Error Type," which determines whether the edit is fatal, or can be overridden as a warning. Other configurable parameters related to an error code include the "Forcible" indicator, which allows the edit to be manually overridden by a Claims Resolver.
- Begin and End dates are used to turn edits on and off, and control when they are applied to claims.
- Agency policies pertaining to the date, service, or discharge are used for determining which adjudication process to use. Our solution also supports easy transition when these policies change.

EPA66

The Contractor's solution shall have the ability to override an auto-deny edit prior to adjudication and the ability to retain the override when a claim is adjusted, and allow for all original edits on an adjustment to be retained and overridden as defined by the Agency

Team CNSI evoBrix X CPMS is capable of overriding an auto-suspend edit prior to adjudication using the mass resurrect process, make use of Error Alternate Dispositions functionality to set Claim Category can as 'System Generated' and use the Alternate Disposition as 'Suspend' and the 'Forcible' indicator as 'Y' will give an ability to retain the override when a claim is adjusted, and allow for all original edits on an adjustment to be retain and overridden as defined by the Agency.

EPA67

The Contractor's solution shall provide online, real-time claims processing functionality to allow authorized users to override certain edit and audit errors, the application of which must be reflected in the audit trail.

Team CNSI's evoBrix X CPMS provides the capability for the State user to override the edit and audit errors to adjudicate the claim manually. All the claim edits will be associated to an error code. The flag on the error code determines if the edit can be suppressed by the Claims resolver during adjudication. The flag on the error codes can be configured. Claims resolver can manually suppress any edit or error if it is allowed for suppression.

EPA68

The Contractor's business rules engine shall be configurable for users to define alerts, notifications, and claim processing business rules.

Team CNSI's solution allows the State to configure the business rules in rule engine to apply the appropriate edits, errors and pricing for Claims. The alerts and notifications are configured through workflow engines. The evoBrix X Core Claims module allows the User to create alerts and these alerts can be triggered by the System automatically as and when the business conditions are met. The Correspondence framework in the evoBrix X Core Claims module will also generate standard correspondences as per the rules defined in the evoBrix X Core Claims module.

EPA69

The Contractor's solution shall provide the ability to configure business rules to be date-specific (e.g., date added, date modified, start date, end date, and effective date) as defined by the Agency.

Team CNSI's CPMS allows DPHHS to configure the business rules in rule engine to apply the appropriate edits, errors and pricing for Claims as appropriate based on the dates of service as shown in Figure 3.10.10-90. Team CNSI's rules engine, RuleIT, maintains complete visibility for each business rule (as shown in Figure 3.10.10-91), including:

- Rule author and created date
- Rule name and description
- Effective dates
- Complete change history
- Option to compare and track multiple versions of the rule
- Rule search based on keywords

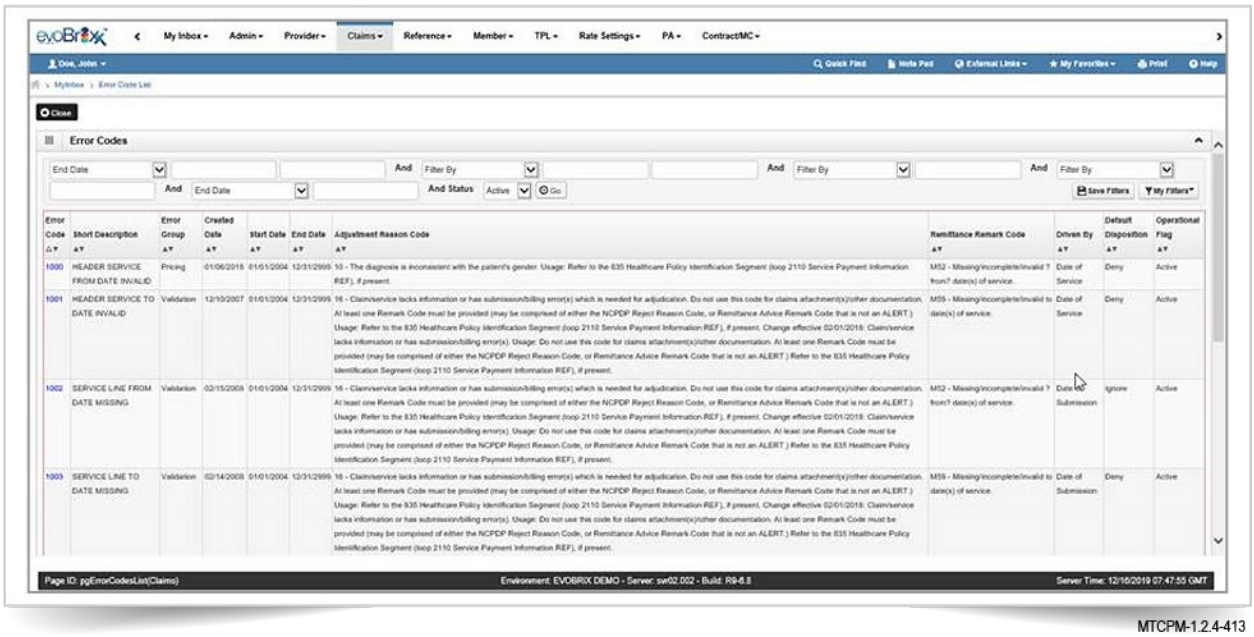


Figure 3.10.10-90. Error Codes with a Start and End Dates. Business rules defined in RuleIT validate the start and end date before applying the edits.

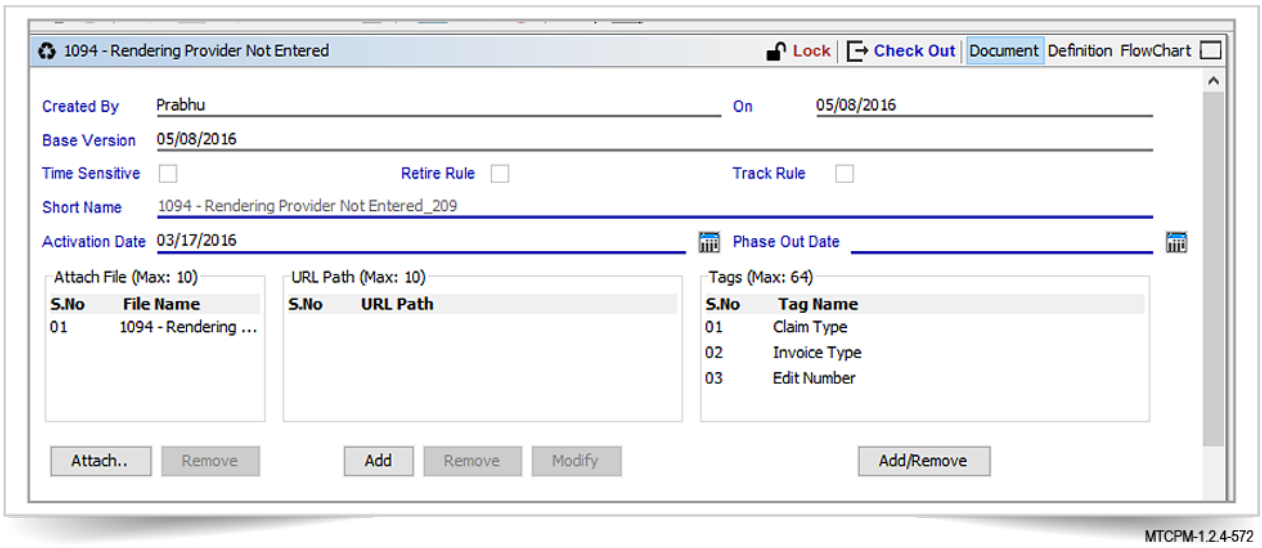
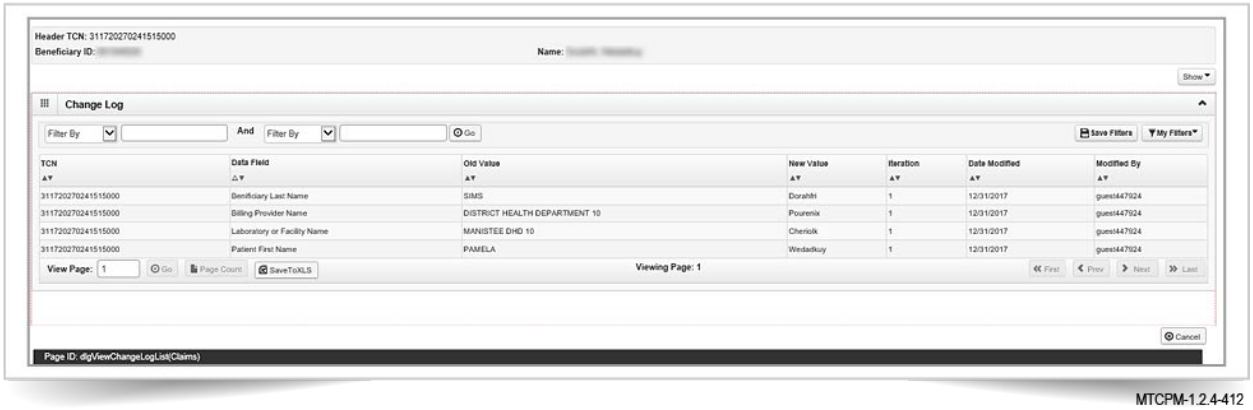


Figure 3.10.10-91. RuleIT Audit Trail. RuleIT captures a detailed history of changes.

EPA70

The Contractor's solution shall provide a complete claims audit trail to track, report, and display all actions made to a claim by the system or a user, including the date of each action and processing step.

Our evoBrix X CPMS has the ability to track and report on claims varied business status to ensure finalization of claims within a specified time frame. The solution can also track all the claim audit trails that were applied on the claim along with the action taken on the claim with date stamp using the claims change log capability as shown in Figure 3.10.10-92.



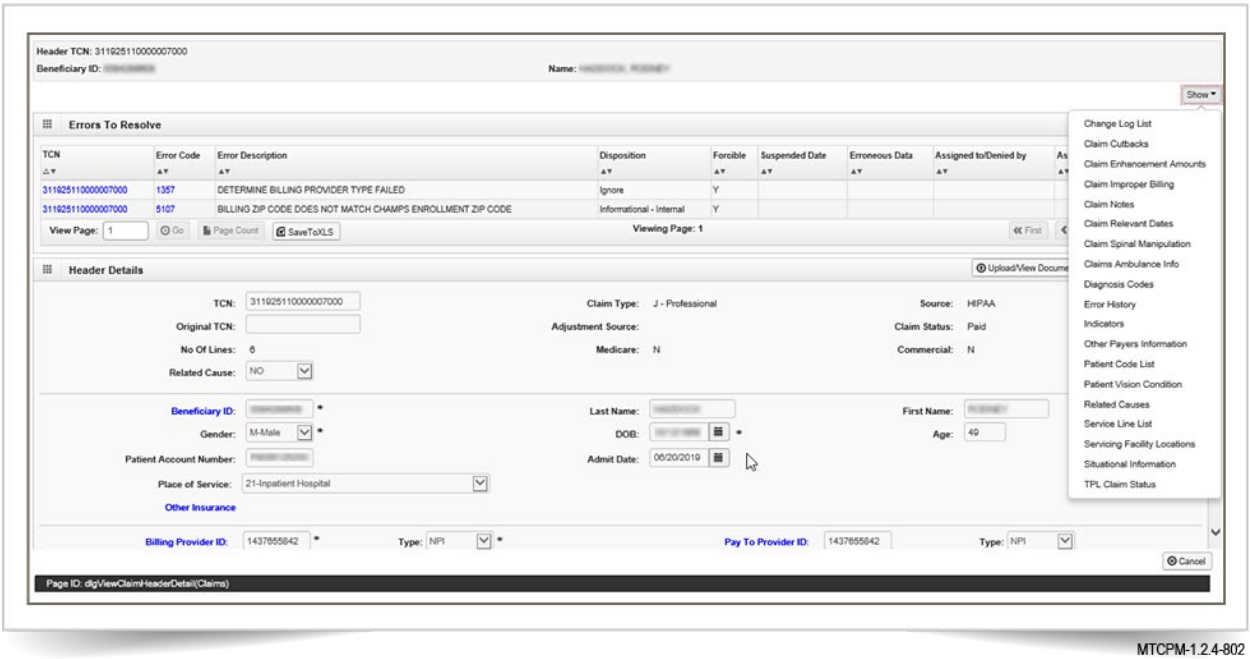
MTCPM-1.2.4-412

Figure 3.10.10-92. Claims Audit Trail. evoBrix X Core Claims module maintains the audit trail of changes made on a Claim.

EPA71

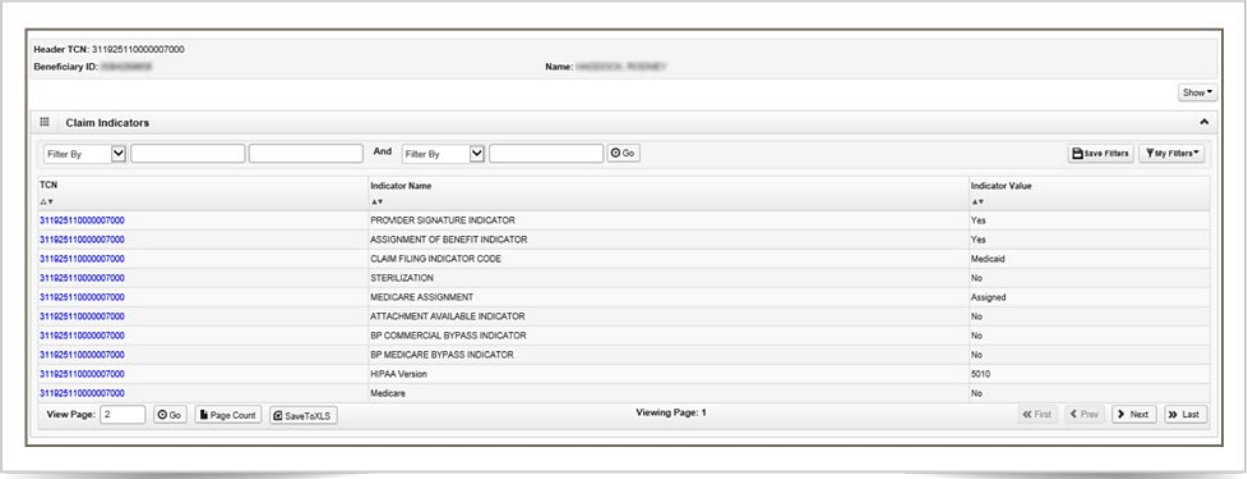
The Contractor's solution shall maintain all data from the adjudication of each claims transactions, as defined by the Agency.

Team CNSI's evoBrix X solution captures all the data utilized and derived during claim adjudication which can be later utilized to assess the trends or to support any investigation. All the data received during the Claims Intake process and any additional attributes derived by the System during the adjudication will be retained in robust database tables and can also be seen on online screen as shown in Figure 3.10.10-93, Figure 3.10.10-94, and Figure 3.10.10-95. Team CNSI will assist in gathering the data which resides in tables to support research or investigation. In addition, DPHHS can also run pre-scheduled reports to view the Claims data.



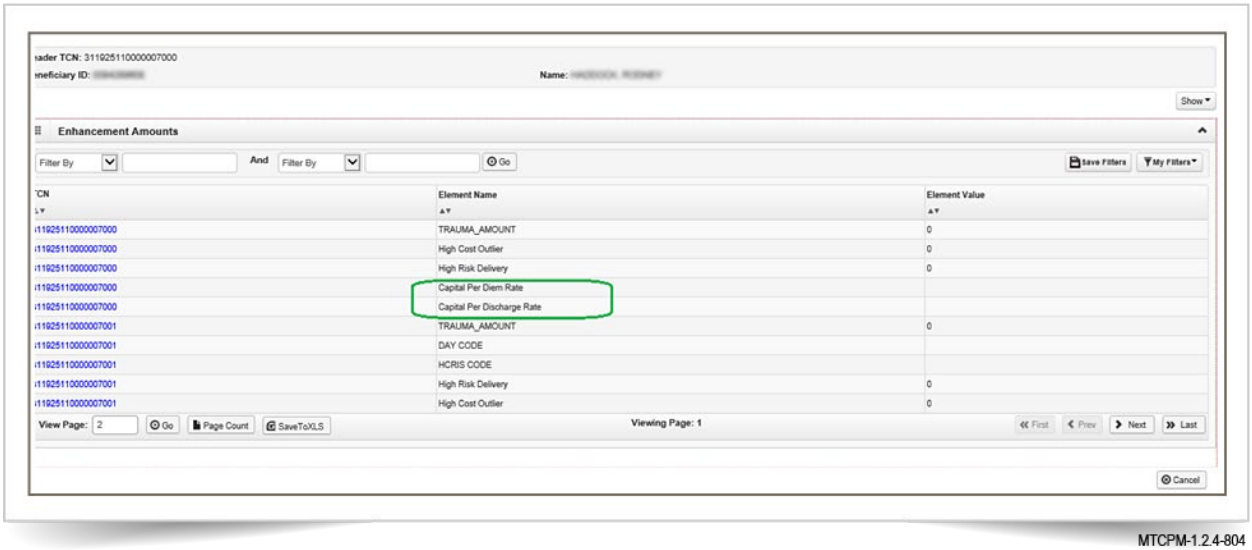
MTCPM-1.2.4-802

Figure 3.10.10-93. Claim Details. The show feature on the online screen contains the data derived by the solution during adjudication.



MTCPM-1.2.4-803

Figure 3.10.10-94. Claim Indicators. The indicators derived by the solution during adjudication



MTCPM-1.2.4-804

Figure 3.10.10-95. Adjudication Derived Amounts. The amounts derived by the solution during adjudication

EPA72

The Contractor's shall suspend claims for manual review or automated reprocessing based on edits that post using configurable business rules.

Team CNSI's evoBrix X platform is flexible and easily configurable, edit-driven process provides the ability to automatically reprocess claims based on DPHHS defined rules. Claims are resurrected or adjusted, through which an existing claim is reprocessed. A claim is categorized as a suspended claim when it goes through the claims adjudication process and encounters edits errors that are configured to not pay or deny the claim. These claims need to be looked at manually and the errors identified in them resolved before passing them through the adjudication process again. The claims supervisor has oversight over the entire claims operational area. The operations coordinator oversees the day-to-day workload of the claims processors by assigning suspended claims that need to be manually reviewed, resolved, and moved to the finalized state. Timeliness, performance, and reporting requirements of Claims Processors working to resolve suspended claims is also monitored by the operations coordinator.

evoBrix X claims adjudication engine has error allocation rules that assign the claim intelligently to Claims processor to resolve suspended claims. The system scans through all of the edits posted on a claim and, based on the specified rules, picks one of the edit's entities to assign the claim to that entity. The entity association to an edit is configurable. evoBrix X maintains a claims resolution location as a configurable element for an edit.

Claim processors access the list of suspended claims assigned to them for resolution using the evoBrix X Resolve Claims List screen. The filter option on the screen is used to locate the assigned claims. The oldest claims in each queue are located at the top of the screen to ensure that those are worked on first.

The claim processor can access all the edits posted for a claim by clicking on the TCN of the claim. This action brings up the claim summary screen with all the errors attached to the claim listed at the top of the page. The claim processor reviews all the errors listed with a disposition of "Suspend" and addresses them, as shown in Figure 3.10.10-96.

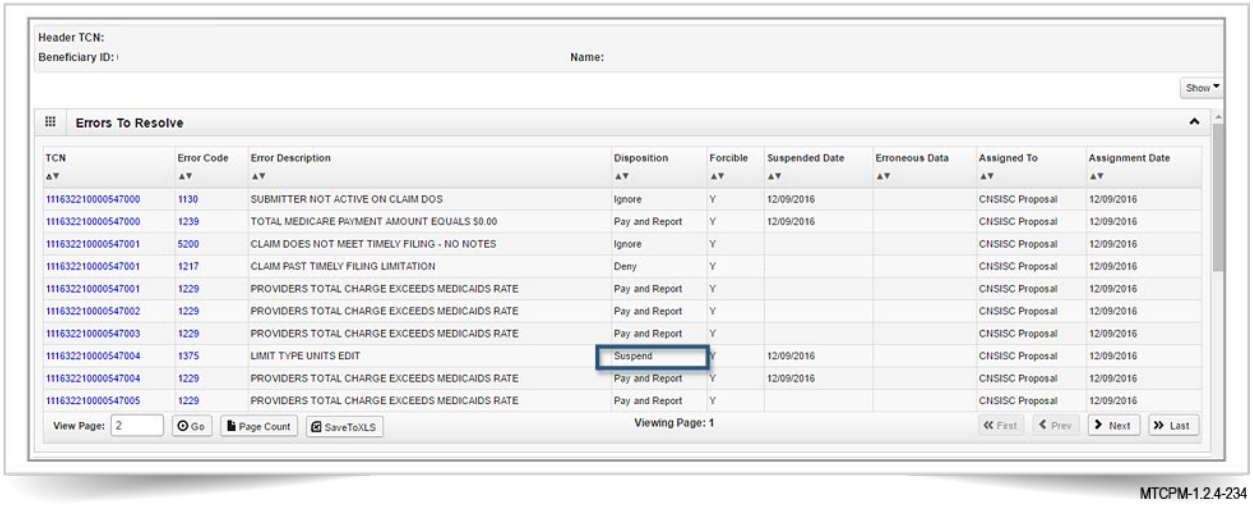


Figure 3.10.10-96. Errors to Resolve. This screen is used to point out each error code and disposition for that code, providing an easy reference for the reviewer.

The claims processor can click on the error code to get a full description of the error and the claim status. Claims processing staff can also reference detailed operational procedures, which provide step-by-step processing guidelines on each business function. Once the review is complete, the claims processor determines the appropriate action to take on the claim as follows:

- Release: Release the claim, which sends it back through the adjudication process
- Refer: Allows the user to assign the claim to a specific individual for their review, such as a nurse or an operations coordinator for support
- Deny: Allows the user to deny the service line that set the error code
- Force: Allows the user to override and allow the service

Claims processors also have the ability to work on multiple claims, to resolve their suspended status, and then release all the claims at once through adjudication, using the "ReleaseAll" feature available to them on the screen. The solution requires customization if the System needs to reprocess the claims automatically based Agency's requirement.

EPA73

The Contractor's solution shall provide, maintain, store, and display a configurable edit hierarchy for all claims transactions and apply the hierarchy during claims adjudication.

Team CNSI's evoBrix X solution comes with configurable rules engine, RuleIT with a rich edits hierarchy for all claim transactions wherein edits are applied in a sequential order during claim adjudication. At the core of the adjudication process is RuleIT, Team CNSI's rules engine, which contains rules for editing and pricing that are required to appropriately adjudicate a claim. Our claims adjudication process applies edit and audit rules for all modules within the system. During this process, edit rules are executed in sequence before a final decision is made on the claim. Figure 3.10.10-97 provides a graphical overview of the edits process and illustrates how each category of edits depends on the data contained in a set of evoBrix X database tables.

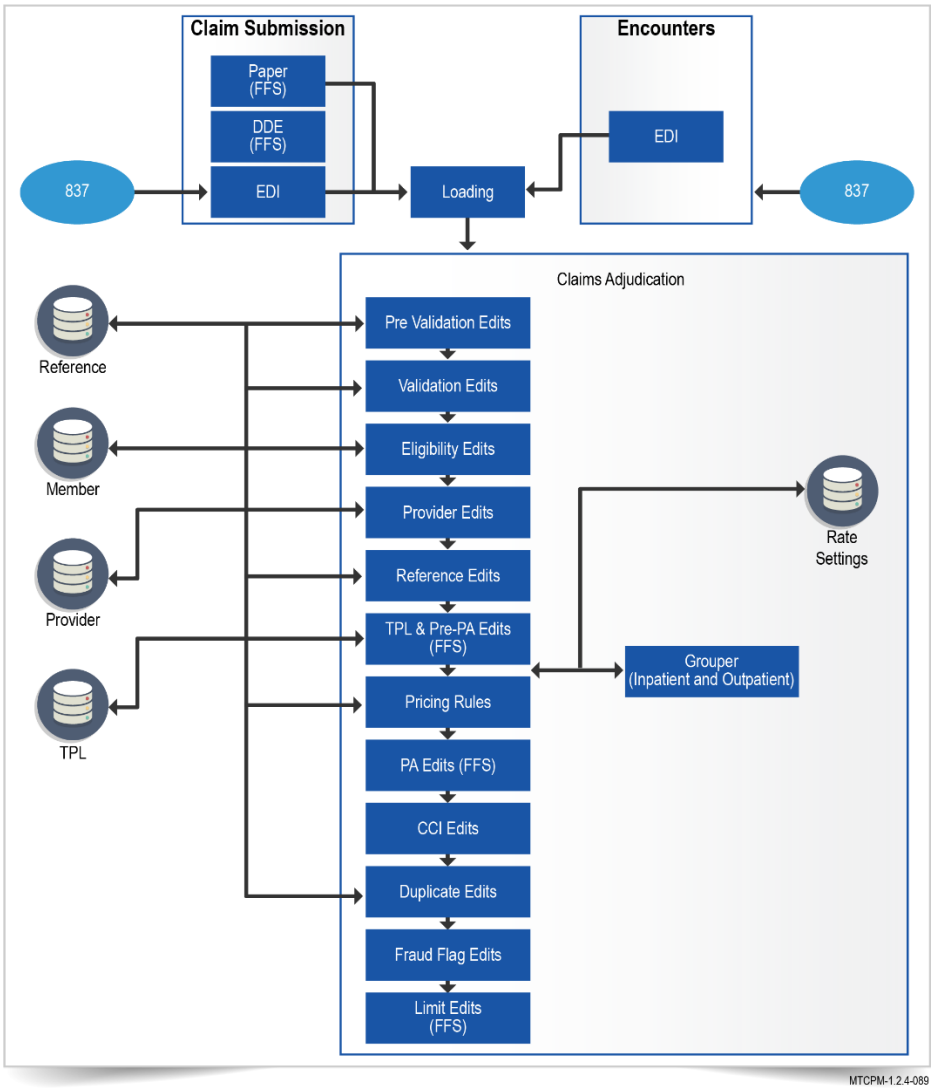


Figure 3.10.10-97. Edit Rules Hierarchy. Team CNSI's evoBrix X solution provides a proven engine for processing claims and encounters.

EPA74

The Contractor's solution shall receive, maintain, store, and display claims transactions data included in a service authorization based on configurable business rules as defined by the Agency.

evoBrix X has a comprehensive data model that supports the storage and maintenance of all service authorization and service utilization information associated with claims transaction data During Claim Adjudication process, each of a service line on a claim is analyzed to determine if the service requires any service authorization. Team CNSI's solution provides the capability to categorize the claims information to include service utilization Service authorization. Service authorization utilization is recorded against the respective authorization record and the utilization information is viewable online. Claims transaction data and service utilization information is available using our claim inquiry capability as shown Figure 3.10.10-98. If a service authorization is available on a claim, the Auth field displays a hyperlink which the user can click on the to display the PA Utilization page, shown in Figure 3.10.10-99.

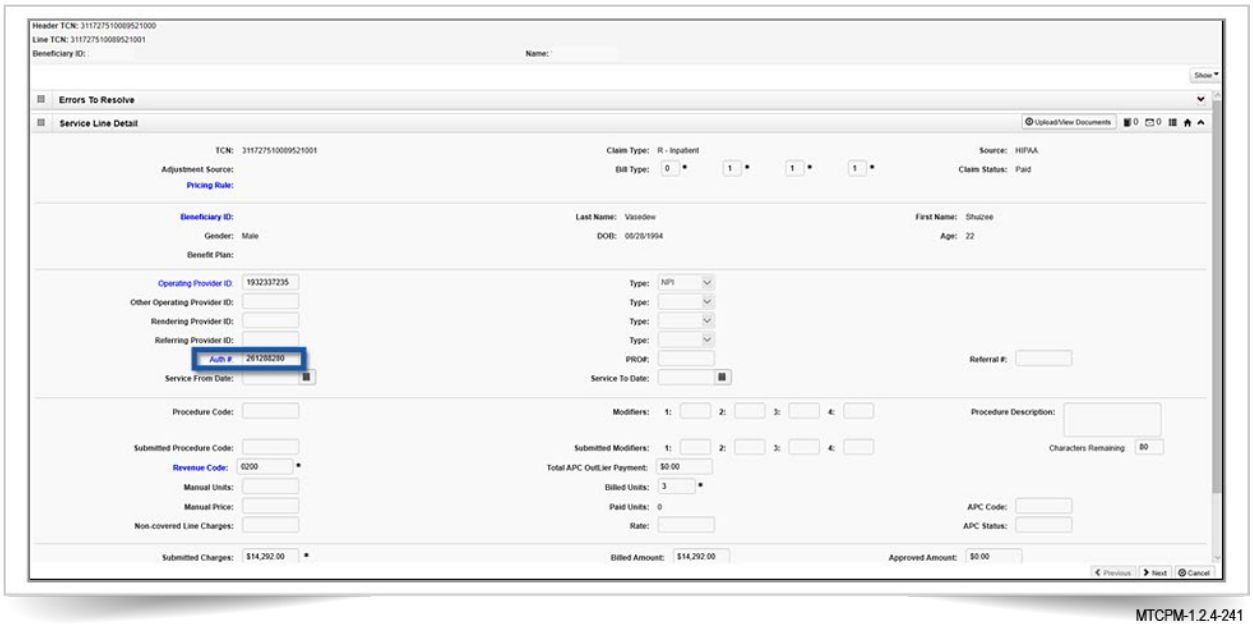


Figure 3.10.10-98. Claims Inquiry - Prior Authorization. Users have the ability to view claims transaction data and service utilization information online.



Figure 3.10.10-99. Service Authorization from Claim Records. Service authorization information is accessible from claims.

EPA75

The Contractor's solution shall identify, maintain, store, display and report the status of all service authorization requests (e.g., approved, denied, in process) as defined by the Agency.

The evoBrix X CPMS solution supports the storage, maintenance, and display of all prior authorizations along with the status of each request, as shown in Figure 3.10.10-100. In addition to the approved and denied prior authorizations, in process prior authorizations are shown to only to the provider and not the business user. In process prior authorizations are not shown to the business user as they are incomplete and have not been submitted by the provider yet.

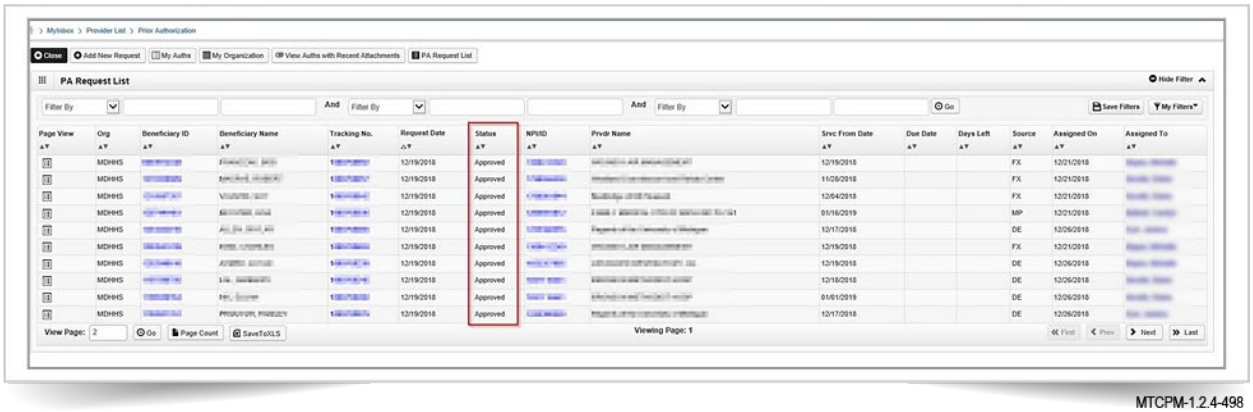


Figure 3.10.10-100. evoBrix X CPMS solution's PA Request List Screen. The solution offers a user-friendly interface with various filter options to search for prior authorization requests.

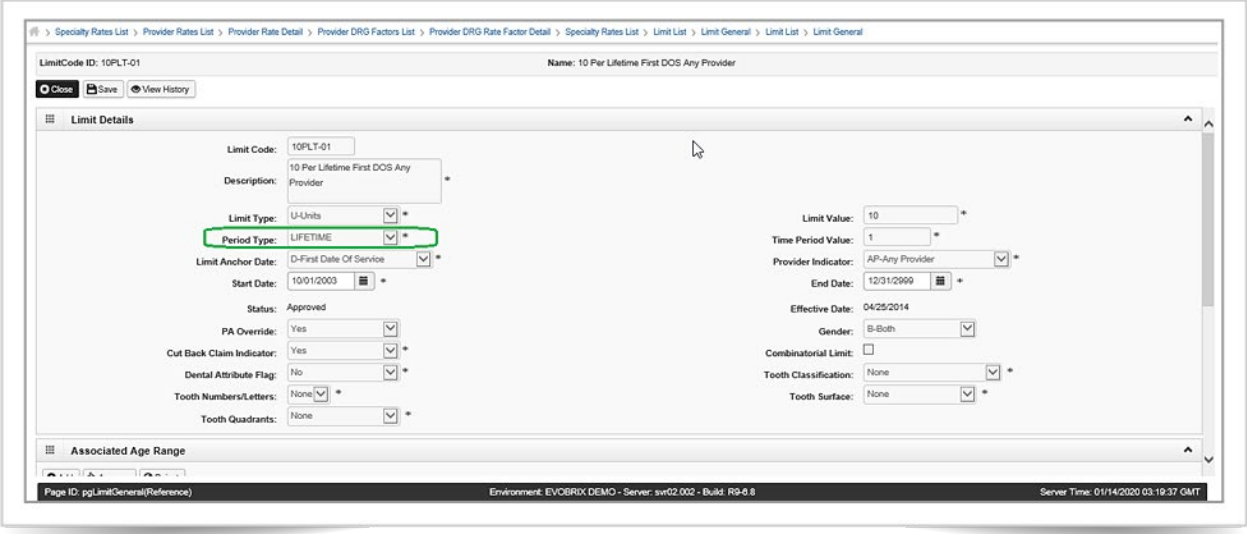
EPA76

The Contractor's solution shall support TPL cost avoidance during the claims adjudication process as defined by the Agency.

The solution ensures that Medicaid is the payer of last resort. Hence, it has all the edits and checks in place to ensure that Claim has already been paid by the third parties especially when it is a COB claim. RuleIT is pre-configured with Medicaid claims edits, audits, and rules which also includes the edits for TPL validation. TPL validation is an integral component of the claims adjudication flow in the Team CNSI solution. Appropriate actions will be triggered based on the outcome of TPL validation, including:

- Denying claims when it is found that the member has active third-party coverage and not submitted on claim as shown in Figure 3.10.10-101.
- Deducting from the to be paid amount, the amount that the identified third party is liable to pay.

When there are multiple payers for a member in the TPL subsystem based on coverage type, the provider is required to submit all other payer information on the claim. If this is missing, the system posts an edit to the claim. The final disposition of the claim is based on the configuration of the edit. This ensures that Medicaid is the payer of last resort.



MTCPM-1.2.4-876

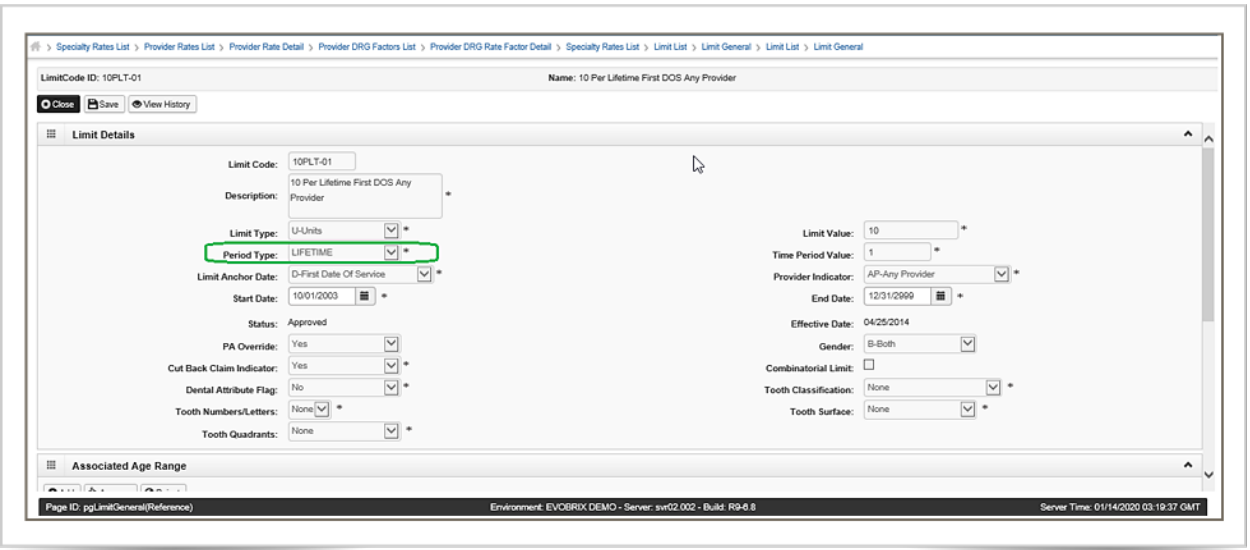
Figure 3.10.10-101. evoBrix X Claims adjudication process denying a claim with TPL discrepancies.

EPA77

The Contractor's solution shall have the ability to adjudicate all claims transactions against one or more service authorization limits (e.g., units, dollars, date ranges, procedures, provider) as defined by the Agency.

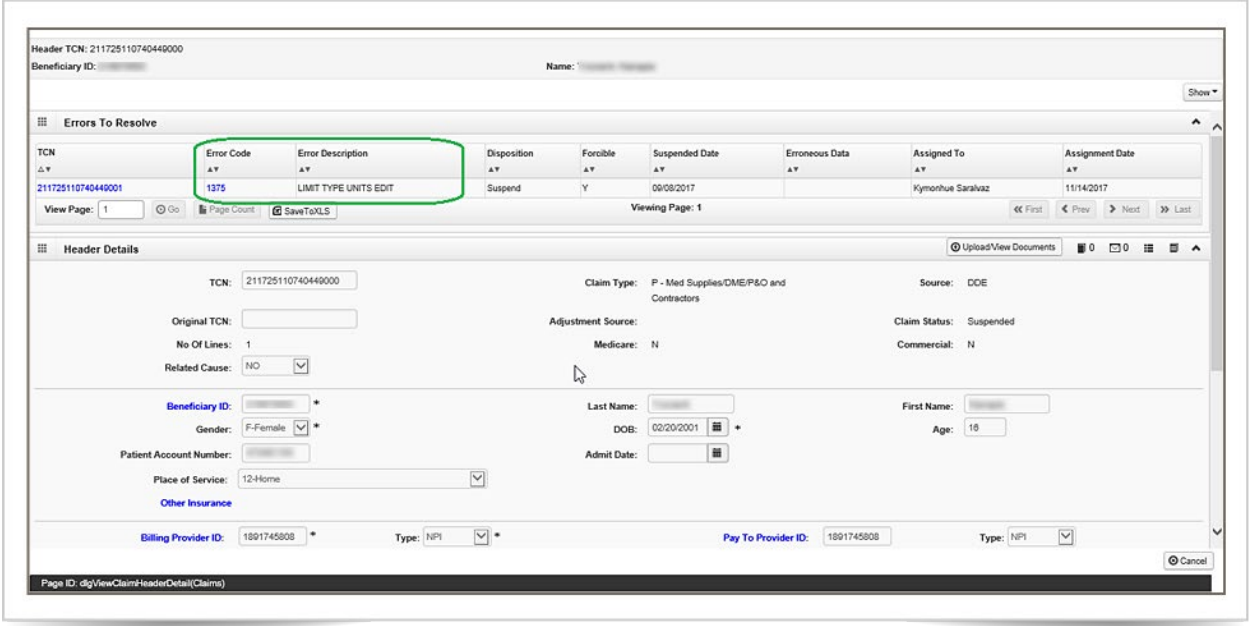
Team CNSI's evoBrix X solution comes pre-loaded with a large number of Edits that focus on limits (e.g., Units, Dollars, date ranges, procedure code, revenue code, diagnosis code, Provider Type, Specialty and Sub-specialty). evoBrix X handles service limitations by configuring limits. Limits are a means by which DPHHS may limit either the units or dollars paid for a particular service or group of services for a client over a specific time period. When the user is establishing the limit criteria the option to automatically cutback any claim exceeding the units/dollars is available to be selected.

Limit criteria are taken into consideration when adjudicating a claim containing a service which is contained on the Limits tables for the claim date of service. All of the previously paid claims for the client which are included in the Limit criteria are accumulated to determine if the payment of this particular claim service will exceed the ceiling established in the limit criteria. Limits are established to cover various periods, including lifetime, year, month, or state fiscal year with evoBrix X administration screens. The limit type can be units or dollars. If the member utilized all the units or dollar amount defined for the service, the claim adjudication process posts the edit. Additional limit edits can be easily configured to meet DPHHS policy. Figure 3.10.10-102 and Figure 3.10.10-103 shows lifetime limits and claim capabilities, Limits are established to cover various periods, including lifetime, year, month, or state fiscal year with evoBrix X administration screens. The limit type can be units or dollars. If the member utilized all the units or dollar amount defined for the service, the claim adjudication process posts the edit. Additional limit edits can be easily configured to meet DPHHS policy. Figure 3.10.10-102 and Figure 3.10.10-103 shows lifetime limits and claim capabilities,



MTCPM-1.2.4-765

Figure 3.10.10-102. Claims Period Type for Lifetime Claims. Team CNSI's solution provides the capability to retain claims marked with period type of "lifetime".



MTCPM-1.2.4-766

Figure 3.10.10-103. Limit Processing for Claims. Once claims met with limit criteria then adjudication process will deny the claim.

EPA78

The Contractor's solution shall create and maintain work queues for adjudicated claims with TPL information identified for members without active TPL for the carrier reported on the claim and automatically produce inquiries to the member and billing provider using their preferred method of communication.

Team CNSI's solution ensures that Medicaid is the payer of last resort. Hence, it has all the edits and checks in place to ensure that Claim has already been paid by the third parties especially when it is a COB

claim. Any deficiencies on the Claim will be sought clarity from Provider and Member through communications. The incoming claim will go through TPL edits and if the solution does not find an active TPL for the member which is present on the claim, then the claim will be suspended. Such claims can be routed to default work queue as defined in the workflow engine. Any claim status inquiry from providers on the suspended claims will be automatically responded with the appropriate reason (TPL discrepancy) as a response. The solution provides a secure inbox to communicate with providers and members who are authorized to access the system. Whenever authorized users sign in, their inbox is displayed. The inbox has announcements, alerts, and other reminders. The alert and notifications are delivered to the users via a secured message to their inbox. It enables e-mail and inbox notification to be associated to an event and workflow. The alert type, along with the alert due data reminds users which work items require their attention. Users can read, responds, forward and delete messages from My Inbox, once deleted they won't be shown to the user anymore in subsequent logins. These are shown to the users based on the user security profiles set up in the system.

EPA79

The Contractor's solution shall configure, support, and maintain all claims business rules (e.g., add, modify, or remove/retire rules) as defined by the Agency.

Team CNSI's RuleIT rules engine allows the State to seamless configure and maintain the claims business rules to satisfy DPHHS policies. The base version of RuleIT has pre-configured edits and audit-related rules. These pre-configured rules will be in place for the MPATH implementation, either as-is or it allows for quick and seamless configuration of any additional adjudication rules. Team CNSI will work with DPHHS to configure, support, and maintain claims business rules throughout the term of the contract to address the requirement.

EPA80

The Contractor's solution shall have the ability to apply claims edits based on a provider's role (e.g., rendering, attending, treating, ordering, referring, prescribing, billing, and pay to).

Team CNSI's evoBrix X Core Claims module has the ability to apply claims edits based on a provider's role. It includes a pre-built comprehensive set of edits configured in the rules engine, RuleIT. The rules configurations include atypical, billing, rendering, pay to, treating, attending, referring, ordering and other provider. Figure 3.10.10-104 details provider edits in our solution.

Edit	Description
1094	RENDERING PROVIDER NOT ENTERED
1116	BILLING PROVIDER ON REVIEW
1117	HEADER RENDERING PROVIDER ON REVIEW
1134	PAY TO PROVIDER NOT ON FILE
1272	OTHER PROVIDER NOT ON FILE
1302	PAYMENT FOR INACTIVE PROVIDER
1316	PAY TO PROVIDER BUSINESS STATUS IS NOT ACTIVE
1369	BILLING PROVIDER HAS STOP PAYMENT INDICATOR
1752	BILLING PROVIDER ENROLLED AS MANAGED CARE ONLY

1771	HEADER PAY TO PROVIDER IS NOT ACTIVE ON CLAIM DOS
5156	ATTENDING PROVIDER MISSING

Figure 3.10.10-104. Provider Edits. Team CNSI's solution has the ability to apply claims edits based on a provider's role.

Edits are created and maintained in Team CNSI's RuleIT rules engine. RuleIT is one of the core components of the evoBrix X solution that enables Team CNSI to offer a configuration-driven approach. RuleIT acts as a centralized business rules repository and empowers Business users to maintain the business rules. The rules engine will restrict billing in accordance with State policy and parameters. The RuleIT composer will be leveraged to make changes to the edits to meet the State's policy. The pre-configured rules are based on the experience gained in implementation of the solution in the states of Michigan and Washington, as well as CMS.

EPA81

The Contractor's solution shall provide searchable options that are applicable to specific business rules (e.g., member, provider, benefits, reference data, claims processing, prior authorization, third party liability (TPL), financial) as defined by Agency

The solution has the search functionality that allows the State to search for any specific business rule as shown in Figure 3.10.10-105. It also allows DPHHS to configure the business rules in rule engine to apply the appropriate edits, errors and pricing for Claims. Team CNSI's RuleIT rules engine maintains complete visibility for each business rule, including:

- Rule author and created date
- Rule name and description
- Effective dates
- Complete change history
- Option to compare and track multiple versions of the rule
- Rule search based on keywords

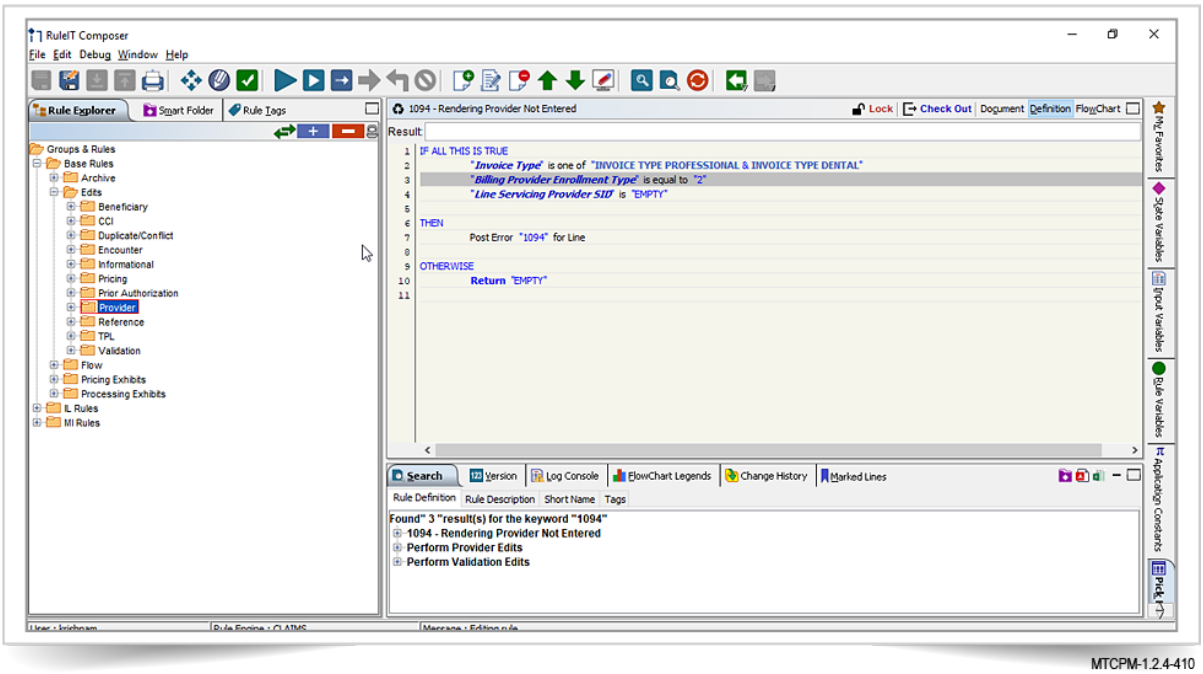


Figure 3.10.10-105. RuleIT Search Capability. RuleIT includes a powerful search functionality using key words.

EPA82

The Contractor's solution shall provide an efficient claims resolution process by presenting the information necessary to work the edit in the edit work item and minimizing the number of navigation steps or the need to view multiple screens.

Team CNSI solution as extensive process for the resolution of suspended claims. A claim is categorized as a suspended claim when it goes through the claims adjudication process and encounters edits errors that are configured to not pay or deny the claim. These claims need to be looked at manually and the errors identified in them resolved before passing them through the adjudication process again. The claims supervisor has oversight over the entire claims operational area. The operations coordinator oversees the day-to-day workload of the claims processors by assigning suspended claims that need to be manually reviewed, resolved, and moved to the finalized state. Timeliness, performance, and reporting requirements of Claims Processors working to resolve suspended claims is also monitored by the operations coordinator. Figure 3.10.10-106 illustrates the claims adjudication process.

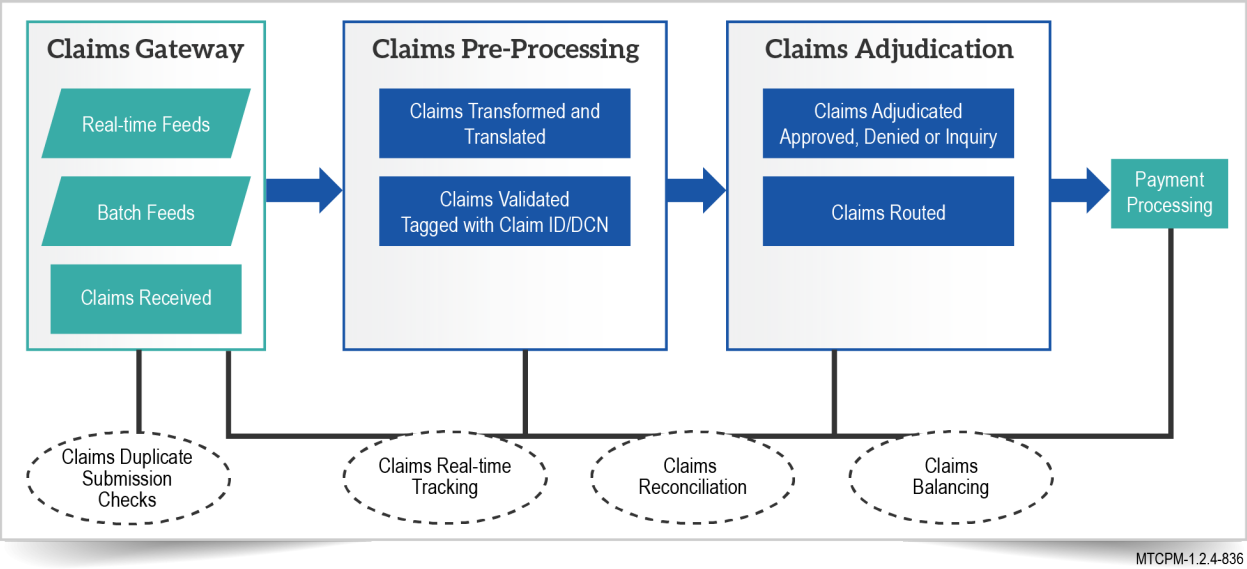


Figure 3.10.10-106. Claims Adjudication Process. Claims are paid, denied or suspended, with suspended claims going through the adjudication process again and not routed to payment processing.

evoBrix X claims adjudication engine has error allocation rules that assign the claim intelligently to the staff member to resolve suspended claims. The system scans through all of the edits posted on a claim and, based on the specified rules, picks one of the edit's entities to assign the claim to that entity. The entity association to an edit is configurable. evoBrix X maintains a claims resolution location as a configurable element for an edit.

Claim processors access the list of suspended claims assigned to them for resolution using the evoBrix X Resolve Claims List. The filter option on the screen is used to locate the assigned claims. The oldest claims in each queue are located at the top of the screen to ensure that those are worked on first, meeting the requirement to complete the claims (except those routed to DPHHS for review) within five business days of receipt. The claim processor can access all the edits posted for a claim by clicking on the TCN of the claim. This action brings up the claim summary screen with all the errors attached to the claim listed at the top of the page. The claim processor reviews all the errors listed with a disposition of "Suspend" and addresses them. The claims processor can click on the error code to get a full description of the error and the claim status.

Claims processing staff are trained in claims suspense resolution and can also reference detailed operational procedures, which provide step-by-step processing guidelines on each business function. Once the review is complete, the claims processor determines the appropriate action to take on the claim. The options available at the top of the Resolve Claims List screen, as shown in Figure 3.10.10-107 are:

- Release: Release the claim, which sends it back through the adjudication process
- Refer: Allows the user to assign the claim to a specific individual for their review, such as a nurse or an operations coordinator for support
- Deny: Allows the user to deny the service line that set the error code
- Force: Allows the user to override and allow the service

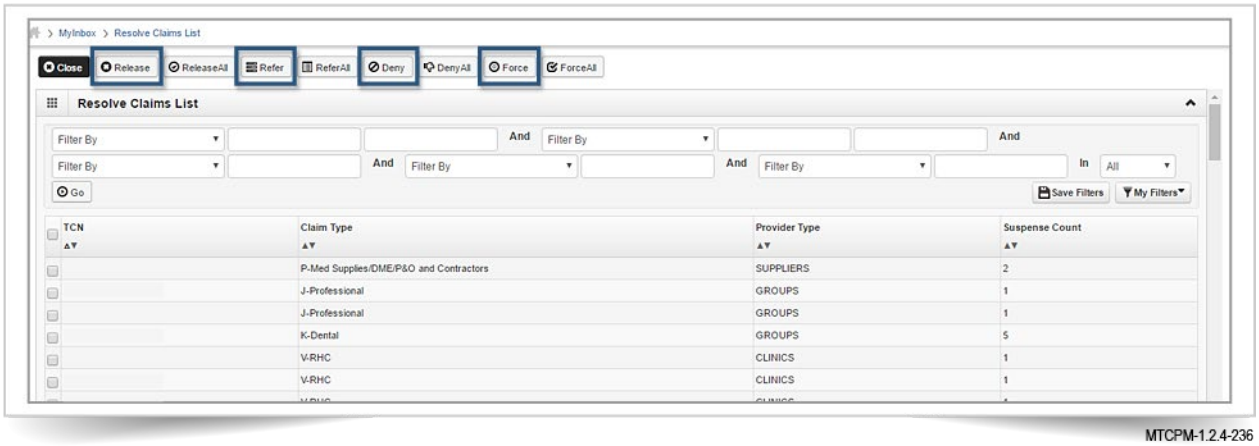
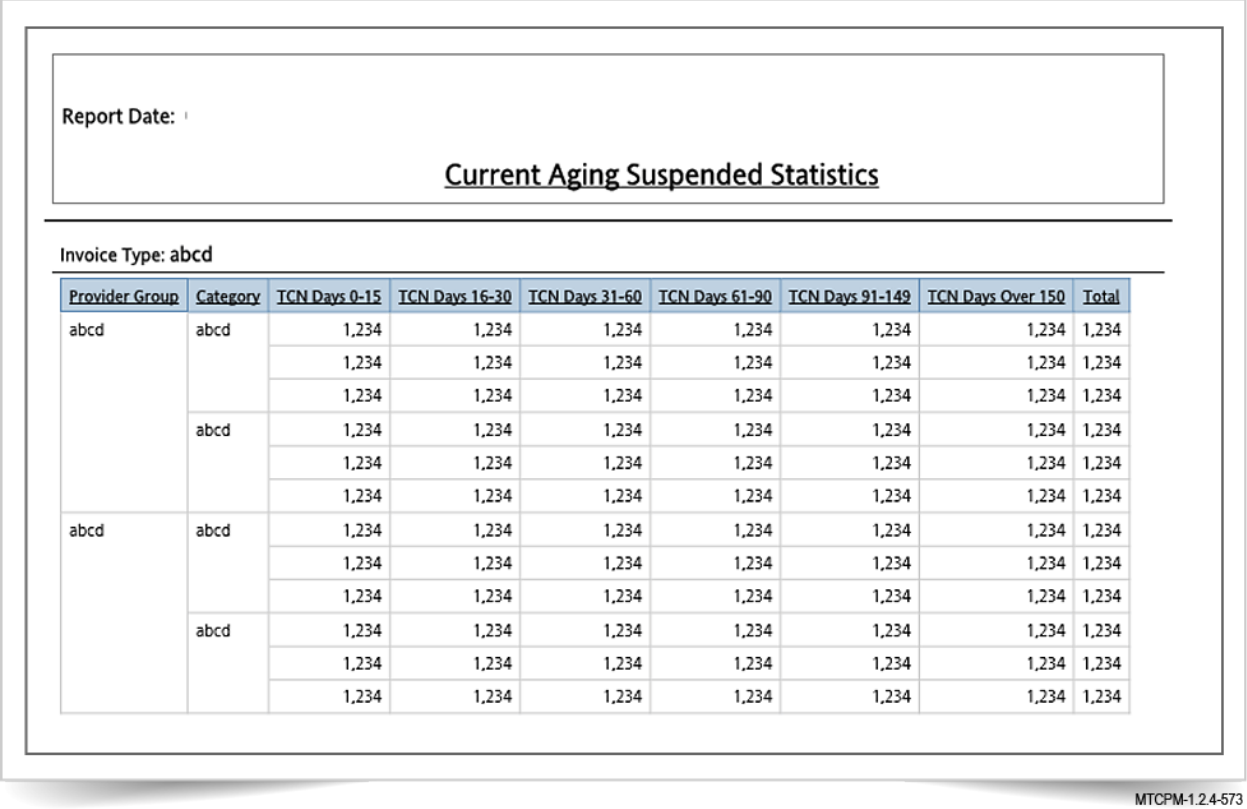


Figure 3.10.10-107. Resolve Claims List. The claims processors use this screen to resolve the suspended claim by taking one of four actions.

Claims processors also have the ability to work on multiple claims, to resolve their suspended status, and then release all the claims at once through adjudication, using the "Release All" feature available to them on the screen. evoBrix provides the capability to generate an on-demand report that lists the claims that have been suspended for a range of days. This report helps the operations coordinator and claims supervisor to keep track of the number of days a claim is suspended and ensure that it does not exceed DPHHS defined SLA. evoBrix X also provides a two weekly Cognos reports as follows: (1) a report that lists the aging of suspended claims, and (2) a report that lists all the suspended claims with the edits posted in each of them. We also provide a Cognos report to enable DPHHS to monitor aging claims, as shown in Figure 3.10.10-108.



Report Date:

Current Aging Suspended Statistics

Invoice Type: abcd

Provider Group	Category	TCN Days 0-15	TCN Days 16-30	TCN Days 31-60	TCN Days 61-90	TCN Days 91-149	TCN Days Over 150	Total
abcd	abcd	1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
	abcd	1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
abcd	abcd	1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
	abcd	1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234
		1,234	1,234	1,234	1,234	1,234	1,234	1,234

MTCPM-1.2.4-573

Figure 3.10.10-108. Suspended Claims Aging Report. The report provides a snapshot of the aging statistics of suspended claims by provider group.

The operations coordinator reviews the report to research and/or re-assign the workload, as needed; for example, if the work is being held up by special circumstances, such as waiting for a provider response or a spike in workload. If a suspended claim has no activity for 15 calendar days after the last processing date, the claim is assigned to the claims processing supervisor for special research and routed to DPHHS. The claim is tracked electronically until it is resolved.

As part of internal business processes, the operations coordinator conducts monthly in-process quality review checks to ensure that each staff member is in conformance with the operational procedures for resolving suspended claims.

EPA83

The Contractor's solution shall provide spenddown editing and accumulation processing as defined by Agency configurable business rules. Additionally, the solution shall maintain information including the dollar amount accumulated toward the spenddown amount, and information identifying all claims applied to the spenddown amount for each eligibility span period.

Team CNSI's evoBrix X CPMS is pre-configured with the spenddown editing and accumulation processing, spend-down amount will be the difference between member income and the Medicaid eligibility limit, as determined by agency over an eligibility span period. Spend-down works almost like a deductible. Member is responsible for paying certain portion of claims as determined by the agency over an eligible span period and once member spend down amount is met for a specific span period then Medicaid will pay the remaining portion of the claim. When a spend-down is applied to a claim then evoBrix X Core Claim module will set the following edit as shown in the Figure 3.10.10-109 below and

maintain the member, dollar amount accumulated toward the spenddown amount, and all claims applied to the spenddown amount for each eligibility span period:

- Edit 1321 - PATIENT PAYMENT AMOUNT HAS BEEN SUBTRACTED FROM AMOUNT APPROVED

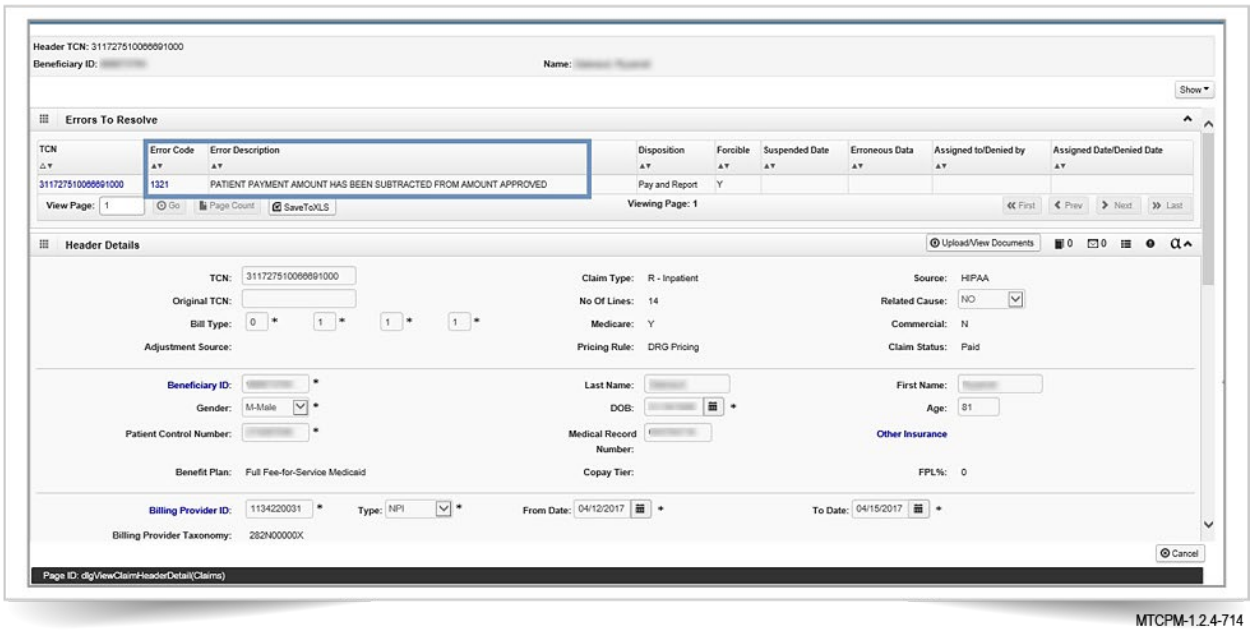


Figure 3.10.10-109. Error Disposition. Team CNSI's solution provides flexible and configurable edit processing capabilities to activate or inactivate any pre-configured edits for claims processing. When a spend-down is applied to a claim then the evoBrix X Core Claim module will set edit 1321 as shown above.

EPA84

The Contractor's solution shall provide a cutback processing for services limited (e.g., pre-certification/prior authorization, dollar amount, additional ancillary services) as defined by the Agency.

Team CNSI's evoBrix CPMS is pre-configured with edit validations for cutback processing, based on the rules defined by DPHHS, claims will be priced, and cutback based on allowed services and cutback services. During limit processing in claims adjudication, it is determined whether there are enough units/dollars available on the limit to pay the units/dollars of the current claim. If there is, adjudication continues. If there are not any units/dollars available to pay anything on the current claim or the Limit criteria did not allow for cutbacks, the appropriate limit error is posted to the claim. If there are some units/dollars available on the limit to pay a portion of the current claim and the limit criteria allows the cutback process, the cutback process will take place as follows:

- 1747 - LIMIT EXCEEDED
  If Limit type is 'D- Dollar' or 'U-unit' and Limit cutback indicator is 'Y' AND member limit dollar amount or units has been reached then post '1747'.
- Limit Edit 1288 - Paid Amount has been Reduced Because of Another Paid Claim. For instance, A procedure of 10 units is allowed to perform on a member in a year and 6 units are already paid by history claims. In such case, if a new claim is submitted with 5 units of the same procedure, then 4 units out of 10 allowed units are paid and remaining 1 unit is mentioned as cutback. Edit 1288 is posted at line level. During the Prior Authorization editing in the claims adjudication, it is determined

whether there are enough units/dollars available on the Prior Authorization to pay the units/dollars of the current claim.

- Edit 1322 – PA Units Cutback and Paid. If claim paid units is greater than authorized units, this edit is posted and the difference of the two units is put in cutback.

evoBrix X CPMS allows configuration of error codes that are mapped to CARC and RARC. At every step of the adjudication process, business logic is executed, and any violation is captured via error codes. This error code signifies the violation of the rule and provides a description of the issues the claim encountered. evoBrix X CPMS then sends the adjustment reason codes and remittance remark codes on the 835 and paper remittance advice to providers explaining the adjustments and denial reasons

EPA85

The Contractor's solution shall provide, as part of the adjustment request, the ability to record a detailed description of the reason for performing adjustments (e.g. mass adjustments, individual adjustments, history only adjustments). Additionally this description shall link to all affected claims/encounters and allow Agency staff inquiry.

Team CNSI's evoBrix X CPMS has a mass adjustment functionality to reprocess claim that are identified for mass claim reprocessing through other mechanisms. Claims operations staff uses the Core Claims module's mass adjustment screen to enter criteria to identify the claims that need to be adjusted. The system has a range of options within the criteria fields that is made available to the claims processor for mass adjustment. The user will be allowed to enter the reason for mass adjustment before submitting the mass adjustment. After the mass adjustments are processed, the mass adjustment Batch number and mass adjustment detail comment (reason for adjustment) will be added to each claim in the batch as shown in Figure 3.10.10-110. The comment will be placed in the Claim Notes field on the replacement / void / resurrected claim. Figure 3.10.10-110 demonstrates the ability to record a detailed description of the reason for performing adjustments and agency can add or update notes and can be link to all affected claims.

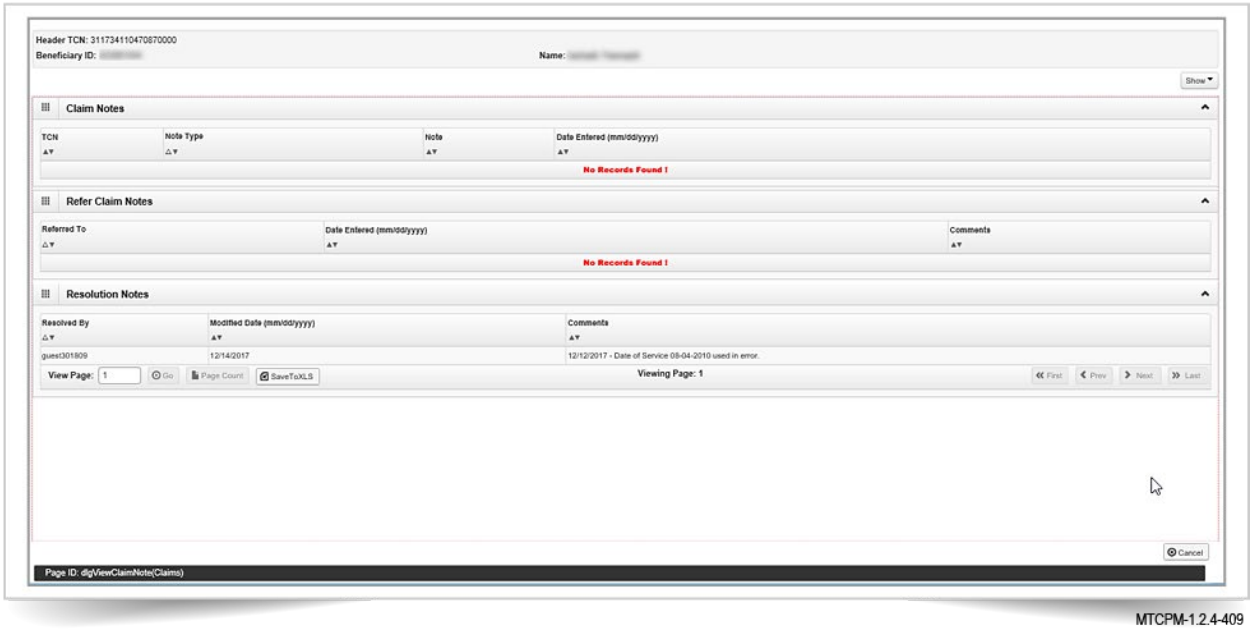


Figure 3.10.10-110. evoBrix X Claims module capture the notes that were made during the resolution process.

EPA86

The Contractor's solution shall provide the ability to generate adjustment notifications (e.g., mass adjustment, gross adjustment, history adjustment, individual adjustment) for user requested adjustments to the Agency user based on Agency defined configurable business rules.

The evoBrix X Core Claims module has the capability to automatically generate letter notifications to appropriate users whenever a claim is suspended for agency defined reasons. The System will be further be customized to leverage this functionality to generate notifications (as defined by agency) whenever a mass adjustment, gross adjustment, history adjustment or individual adjustment is triggered in the System.

EPA87

The Contractor's solution shall provide the ability for the adjustment (e.g. mass adjustment, individual adjustment, history only adjustment) process to maintain claim specific recoupments as specified by Agency configurable business rules.

The evoBrix X Core Claims module identifies the net negative amounts from claim adjustments and recoupments and automatically calculates the provider recoupment amounts as shown in Figure 3.10.10-111. After determining the recoupment amounts, account receivable records are created by grouping the transactions by the providers and adjustment sources and process those credits. These credits are used to offset any payments to be paid to providers. The Team CNSI evoBrix X solution is configured to identify history-only recoveries and payments. It is pre-built to process void and adjustment requests of previously paid claims as shown in Figure 3.10.10-111 and Figure 3.10.10-112.

The system retains the claims information indefinitely and supports mass, individual, history only adjustment, gross adjustment and recovery requests. Further, it tracks the user who has initiated the change request, the adjustment reason submitted, and the data being changed in the claim(s).

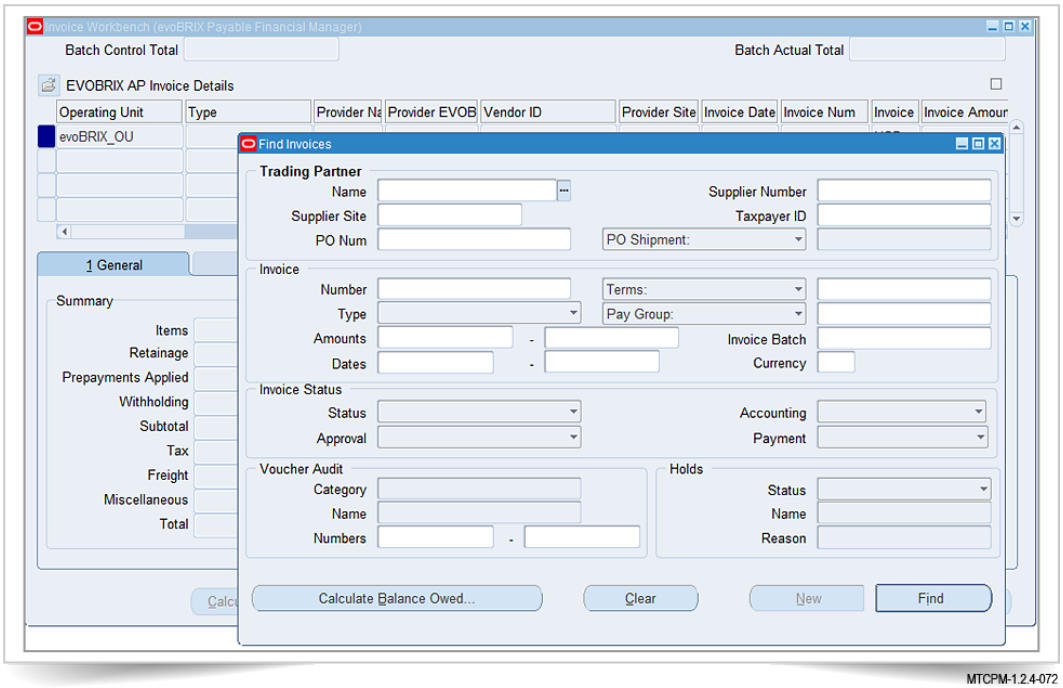


Figure 3.10.10-111. Claims Specific Recoupment. Claims inquiry screen to show claim specific recoupments.

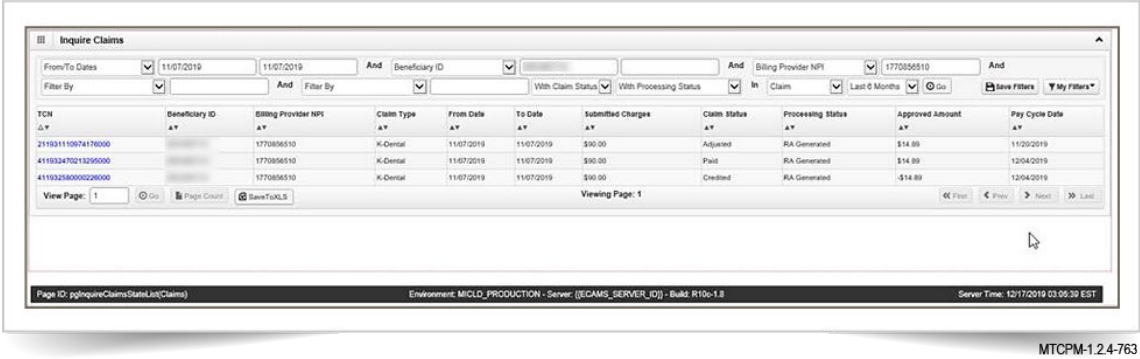


Figure 3.10.10-112. Claims Adjustments and Voiding. evoBrix X has pre-built to process void and adjustment requests of previously paid claims

EPA88

The Contractor's solution shall provide the ability to update applicable systems after data validation and processing of claims as defined by the Agency.

Team CNSI's evoBrix X Core Claims module features a configurable Interface Service Repository (ISR) that can facilitate the transmittal of both batch and real-time data between the evoBrix X CPMS and Agency-approved systems. Complying with MITA standards, the solution can handle industry standard file formats such as proprietary flat files, CSV, fixed length, XML, and all delimited file formats. Additionally, data exchange and file transmissions are handled by the ISR in a secure manner with external Agency-approved entities using SFTP, FTPS, and SSL. Once the data is received, Team CNSI's evoBrix X CPMS Operational Data Store (ODS) is used to maintain transactional, reference, and information from external data sources such as case information based on retention policies. The ODS helps integrate and establish a logical and functional relationship between various data marts that contain data internal and external to the evoBrix X CPMS. The data will be sent to the System Integrator in a pre-defined format to supply the data for other sources.

EPA89

The Contractor's solution shall perform real-time edits (e.g., member, date of service, service/supply code) against pharmacy DME claims to prevent duplicate claim submission based on Agency defined configurable business rules.

While nightly batch processing is the preferred option, the evoBrix X Core Claims module has the option to conduct near real-time and real-time claims adjudication (if there is any scenario that warrants this approach) against pharmacy DME claims to prevent duplicate claim submission.

Team CNSI's evoBrix X CPMS solution has capabilities to receive and maintain member attributes such as demographics, eligibility and authorization details along with eligible benefit services and supplies. These details are utilized during DME claims adjudication for both real-time and batch processes.

Team CNSI's evoBrix X Core Claims solution has pre-configured editing for duplicate claim to proactively identify improper activity and fraud and abuse. The solution edits new claims against previously adjudicated and in-process claims to check for duplicates using configurable business rules. After checking for a duplicate claim, our solution determines whether a current claim is an exact or suspect duplicate of a previously paid claim. Upon finding a "paid" or to be paid" claim, our adjudication engine references the defined criteria to post edits where the configured elements are matching. The solution will be customized to edit the medical claims based on pharmacy adjudicated claims.

In the screenshot below, Figure 3.10.10-113, the evoBrix X Core Claims solution applies edit '1225 – Exact Duplicate of a Paid Claim in System History' after performing a duplicate check.

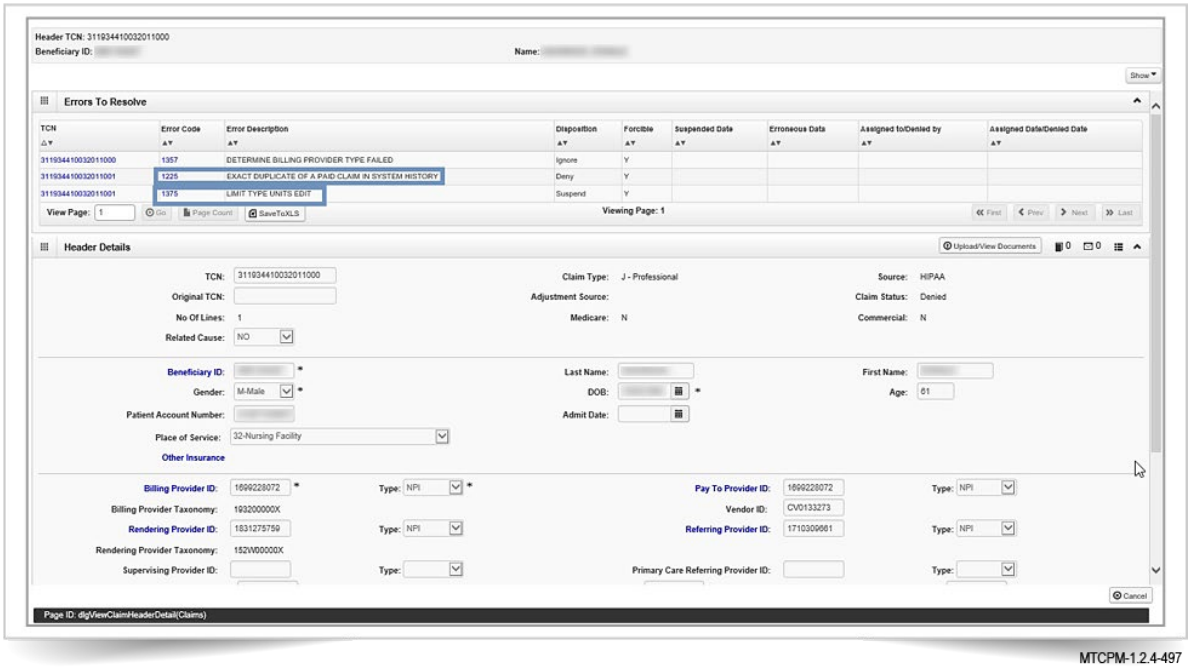


Figure 3.10.10-113. evoBrix X Core Claims module's Claims Detail Screen with the Error Code. The evoBrix X Core Claims solution applies limits and duplicate edits.

Our solution provides functionality for our claims staff to define "exact duplicate" and "suspect duplicate" edit criteria and allows users to manage duplicate criteria through online screens, as shown in Figure 3.10.10-114.

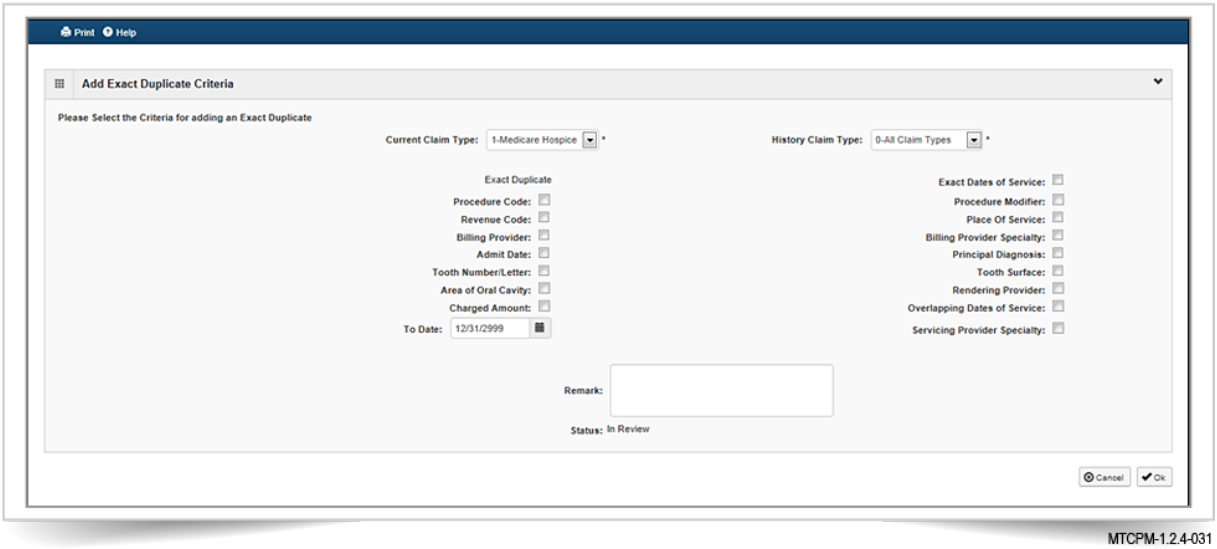


Figure 3.10.10-114. Audits Supporting Duplicate Checks. Team CNSI's solution provides the capability to define exact duplicate criteria based on claim attributes.

These duplicate edits could be extended with additional edits based on trends and other mechanisms for proactive editing. Team CNSI will collaborate with the State to elicit, analyze, and document additional business rules and policies. This information will be used to create or modify RuleIT rules and configuration data.

EPA90

The Contractor's solution shall reprocess suspended claims transactions based on configurable business rules by edit type as defined by the Agency (e.g., system cycle frequency, total number of days before the claim is finalized, suspense location/work queue).

Team CNSI's evoBrix X CPMS has an integrated workflow engine to assign claims to specific workgroups when the underlying conditions are met. Assignment of the workgroup is driven based on claim parameters such as invoice type, claim type and the edit groups. The edit groups that suspend a claim for a valid business scenario can be configured in the workflow engine. The workflow engine will assign all such suspended claims to a special workgroup to take further actions. System will reprocess the claims as per the latest adjudications rules as soon as a suspended claim is released for adjudication.

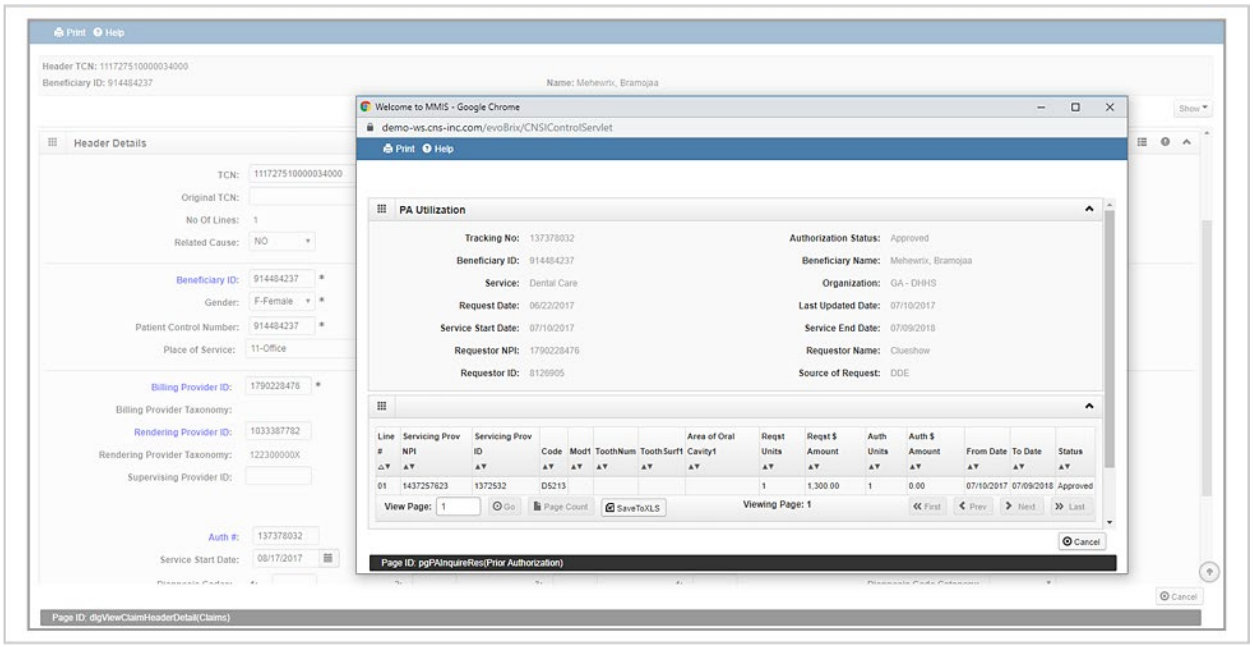
EPA91

The Contractor's solution shall have the ability to view from the claim, the service authorization details used for adjudication, as defined by the Agency.

Team CNSI's evoBrix X Core Claims module will be configured to have the ability to view from the claim, the service authorization details used for adjudication. To view the service authorization details from the claim, Provider enters the service authorization number during the claim's submission through claims direct data entry screen.

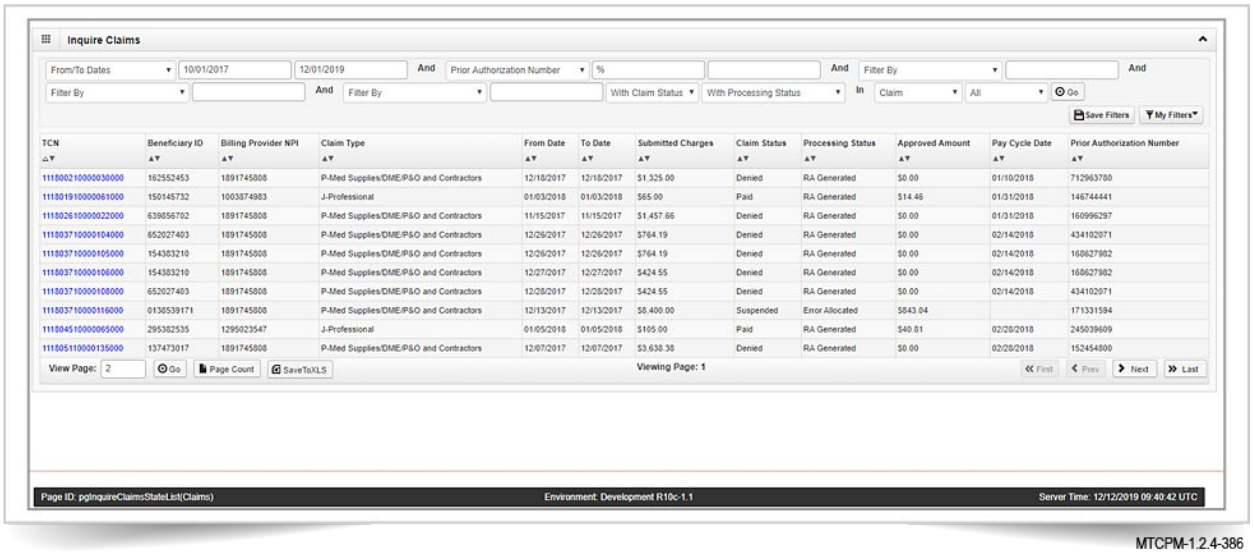
The evoBrix X Core Claims module will validate the service authorization details during claims adjudication and will load the details in the system.

The solution will allow the state worker to view the service authorization number from Inquire Claims screen as shown in Figure 3.10.10-115. Upon clicking the TCN hyperlink, system navigates the worker to Claim Header or Line Detail screen respectively, where the worker would be able to see "Auth #" label hyperlink along with value in the text field in Header Details or Line Details section. Once the user clicks on the "Auth #" hyperlink, the system navigates to the Service Authorization Utilization screen where the solution shows the service authorization details used for adjudication by the claim as shown in Figure 3.10.10-116.



MTCPM-1.2.4-329

Figure 3.10.10-115. Inquire Claims Screen Used to Access Service Authorization Details. Team CNSI's solution provides the capability to define exact duplicate criteria based on claim attributes.



MTCPM-1.2.4-386

Figure 3.10.10-116. Service Authorization Utilization. Team CNSI's solution captures service authorization details used for adjudication by the claim.

EPA92

The Contractor's solution shall have the ability to view from the service authorization all (e.g., paid, denied, adjustments, suspended) claims adjudicated against the service authorization, as defined by the Agency.

Team CNSI's evoBrix X solution can be customized to have the ability to view from the service authorization, all claims adjudicated against the service authorization. evoBrix X solution is capturing all paid, denied, adjustments, suspended history details and can configure to have the ability to achieve the agency's requirement.

EPA93

The Contractor's solution shall edit medical claims against adjudicated pharmacy claims transactions from the pharmacy system to ensure that the service or product (e.g. DME) has not already been paid on a pharmacy claim using configurable business rules as defined by the Agency.

The evoBrix X Core Claims module has the capabilities to receive, store, and assign a TCN to adjudicated Medicare Part-D pharmacy claims information from the pharmacy system. The Medicaid member dual eligibility and corresponding claims information is linked and available for viewing at the individual claim level. The calculated claim amount includes all medical assistance payments including pharmacy dollars and is used to report and support federal payments payable under the Medicare Part D claw-back. The system also supports the ability to view pharmacy claims processed by the PBM. The evoBrix X CPMS provides flexibility to extend RuleIT rules engine to customize edits as business rules defined by the Agency for medical claims against adjudicated pharmacy claims transactions. Figure 3.10.10-117 and Figure 3.10.10-118 shows pharmacy claims for a member with details of each claim, respectively.

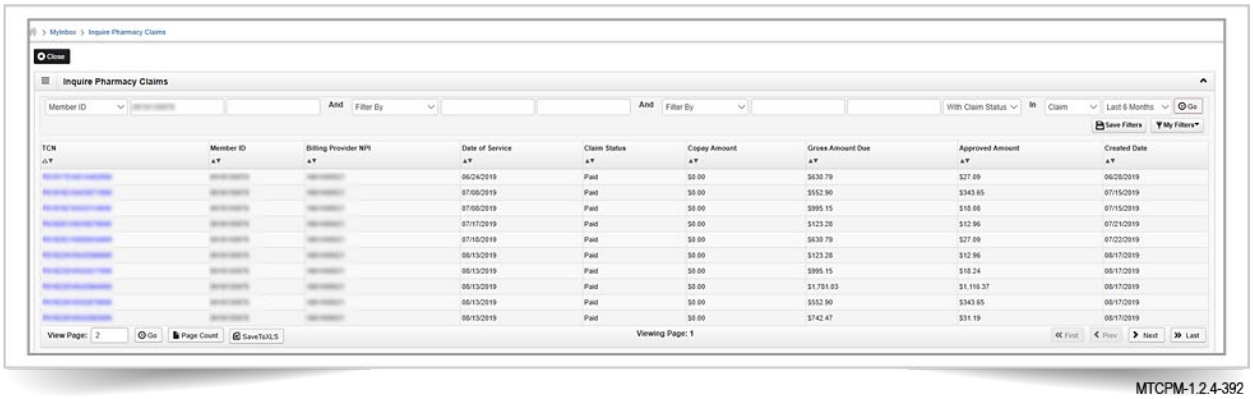


Figure 3.10.10-117. Pharmacy Claims Listing. Team CNSI's evoBrix Core Claims module has the capabilities to receive, store, and assign a TCN to adjudicated Medicare Part-D pharmacy claims information from the pharmacy system.

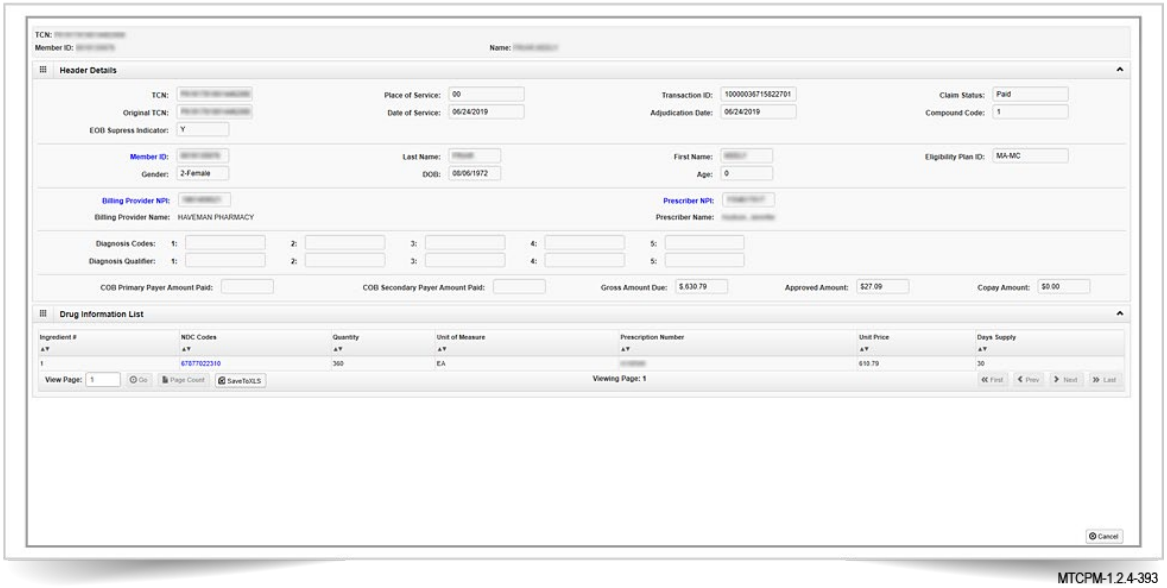


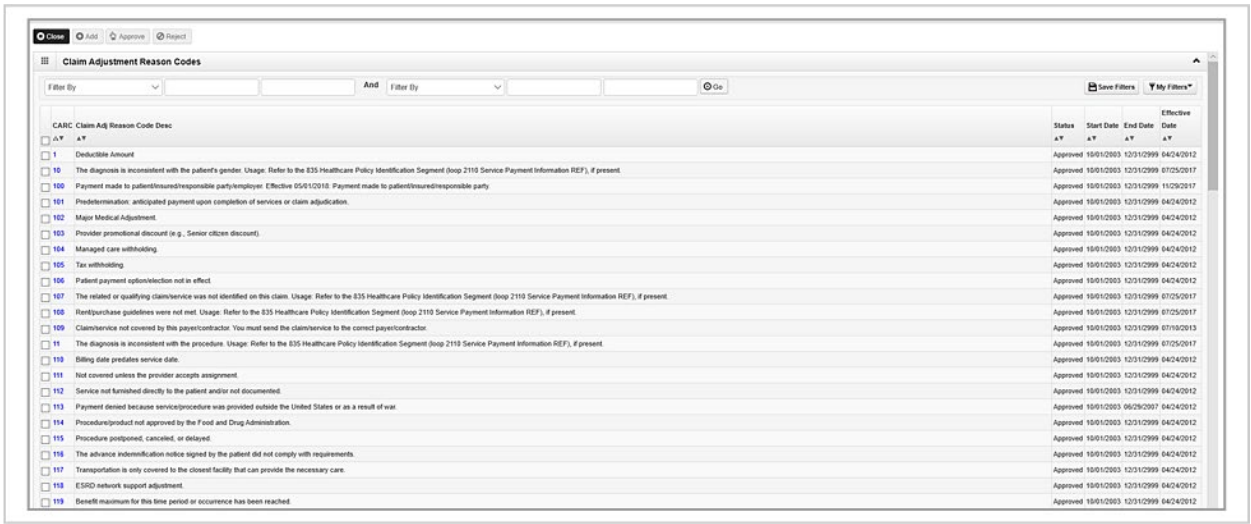
Figure 3.10.10-118. Pharmacy Claim Transaction Detail. Team CNSI's evoBrix Core Claims module has the capabilities to receive, store, and assign a TCN to adjudicated Medicare Part-D pharmacy claims information from the pharmacy system.

EPA94

The Contractor's solution shall receive, store, maintain, and display Explanation of Benefit (EOB) codes, adjustment reason codes, and exception codes. Additionally the Contractor will map these codes to their respective CAQH CORE standard codes for processing X12 transactions (e.g., 837, 835.) The Contractor's solution shall support configuration for valid values for both of these code sets and support standard values for X12 837 and X12 835 files.

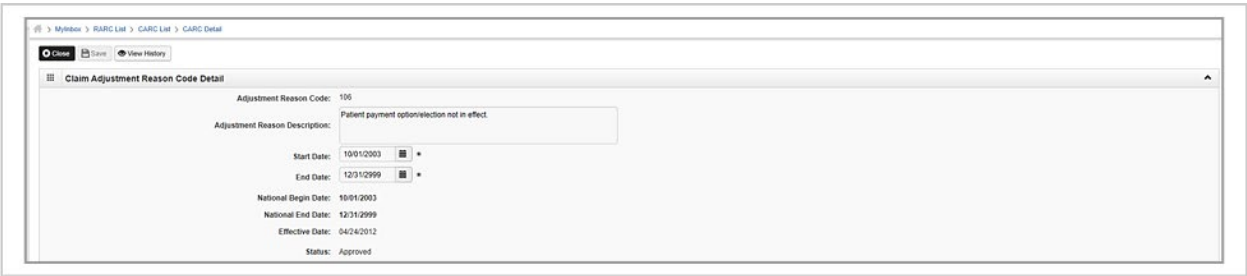
Team CNSI's evoBrix X CPMS has capability to process X12 837 and X12 835 standards and code set and is in compliance with CAQH Core standards. Team CNSI's solution allows configuration of error codes that are mapped to CARC and RARC, as shown in Figure 3.10.10-119, Figure 3.10.10-120, Figure 3.10.10-121, and Figure 3.10.10-122. At every step of the adjudication process, business logic is executed, and any violation is captured via error codes. This error code signifies the violation of the rule and provides a description of the issues the claim encountered. evoBrix X CPMS then sends the adjustment reason codes and remittance remark codes on the 835 and paper remittance advice to providers explaining the adjustments and denial reasons.

When a claim does not fully meet all of the rules and validations that are ran against it, the claim gets an error code assigned to it. This error code, again, is highly configurable through the evoBrix online screens. Each error code has standard CARC and RARC attached to it that will provide valuable information to the provider as to the final resolution of the claim. Properties attached to an error code include "Error Type," which determines whether the edit is fatal or can be overridden as a warning. Other configurable parameters related to an error code include the "Forcible" indicator, that allows the edit to be overridden by a Claims Resolver, error disposition, begin dates, and end dates. Begin and end dates are used to turn edits on and off and control when they are applied to claims. This enables the claims adjudication process to use the DPHHS policies applicable for the date or service or discharge and supports easy transition when policies change. Team CNSI's evoBrix X CPMS also provides the ability to associate a standard HIPAA Adjustment Reason Code and Remittance Remark Code to each edit, so that these are correctly displayed on the X12 835 transaction.



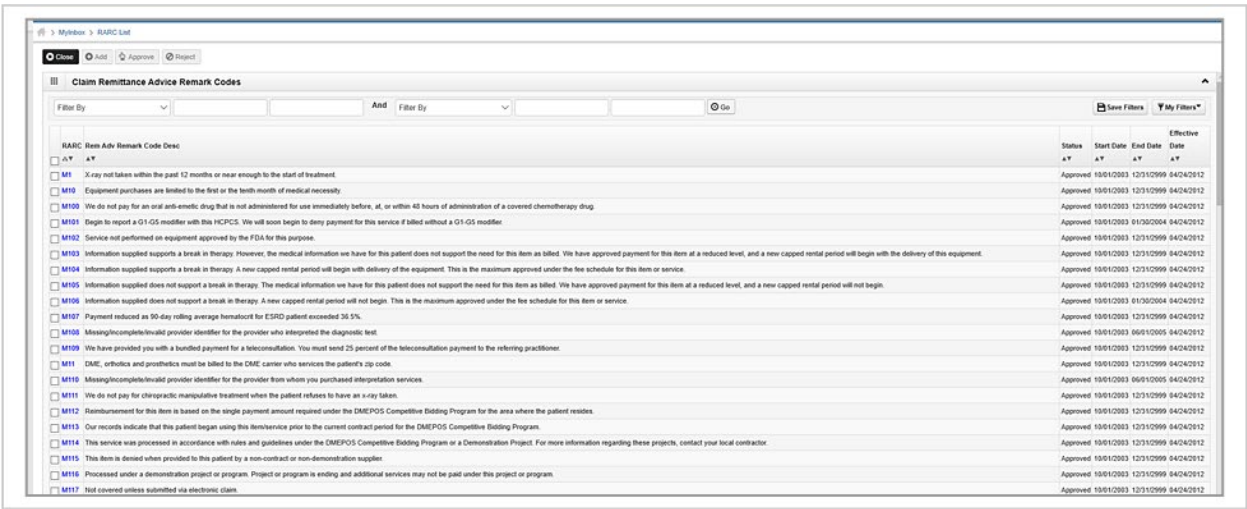
MTCPM-1.2.4-325

Figure 3.10.10-119. Claim Adjustment Reason Code. Team CNSI's Core Claims module supports standard claim adjustment reason codes.



MTCPM-1.2.4-326

Figure 3.10.10-120. Claims Adjustment Reason Code Detail. CARC data may be configured through administration screens.



MTCPM-1.2.4-327

Figure 3.10.10-121. Remittance Advice Remark Codes. Team CNSI's Core Claims module supports remittance advice remark reason codes.



MTCPM-1.2.4-328

Figure 3.10.10-122. Remittance Advice Remark Code Detail. RARC data may be configured through administration screens.

Team CNSI's evoBrix X CPSM solution can easily configure to revive and store the Explanation of Benefit (EOB) codes and agency can configure to map these codes to their respective processing.

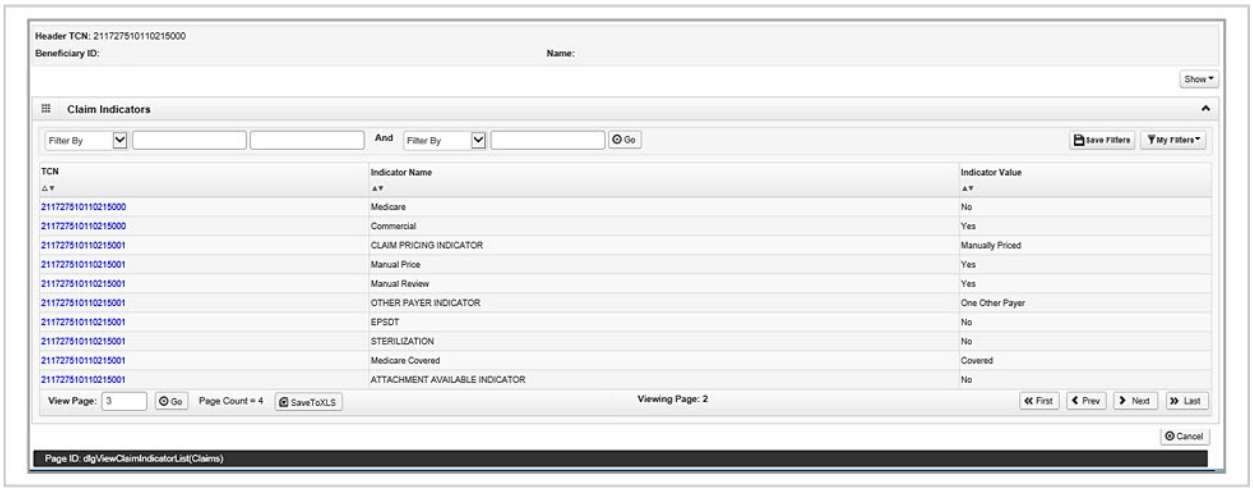
EPA95

The Contractor's solution shall have the ability to override the approved premium payment amount as defined by the Agency.

Team CNSI's evoBrix X Core Claims module can override the approved payment amount by using the manual payment process functionality. The system provides the capability to define the manual pricing

indicator on the procedure code, as shown in Figure 3.10.10-123. During adjudication if manual price is derived then adjudication process will override the approved payment amount with manual set amount on the claim. Our solution verifies the billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage (either above or below), then the claim is flagged and processed for manual review and can override the approved payment amount manually for:

- Possible incorrect procedure
- Possible incorrect billed amount when too high, possible need for individual consideration.



MTCPM-1.2.4-312

Figure 3.10.10-123. Manual Pricing Indicator. Claim Manual Price to override the approved premium payment amount.

EPA96

The Contractor's solution shall update cost and unit balances to applicable service authorizations on a claim during the claims adjudication process.

evoBrix X can authorize and issue service authorizations for service(s) to be provided for a member. When a service has been prior authorized the user defines either the maximum number of units or the maximum dollars to pay for these services over the service authorization time period. During the adjudication process, the service authorization data is reviewed to ensure that there are enough units/dollars available on the Prior Authorization and apply the service authorization cost and unit balances (quantity and dollar amounts) for all the matching services lines.

During the service authorization editing in the claim adjudication, it is determined whether there are enough units/dollars available on the Prior Authorization to pay the units/dollars of the current claim. If there are, adjudication continues to pay the claim and the claim paid units/dollars are added to the utilization used tables associated with the service authorization information. If there are no units/dollars available on the Prior Authorization to pay on the current claim, the following error is posted on the claim.

- Edit 1123 – Prior Authorization Units or Dollar unavailable
  Description: If amount or units authorized for a Prior Authorization are fully utilized and not available for current claim, post edit.

Claims transaction data and service utilization information is available using claim inquiry capability as shown in Figure 3.10.10-124 Claims Inquiry - Prior Authorization. Users have the ability to view claims

transaction data and service utilization information online. If a service authorization is available on a claim, the Auth field displays a hyperlink which the user can click on the to display the Prior Authorization utilization page, shown in Figure 3.10.10-125.

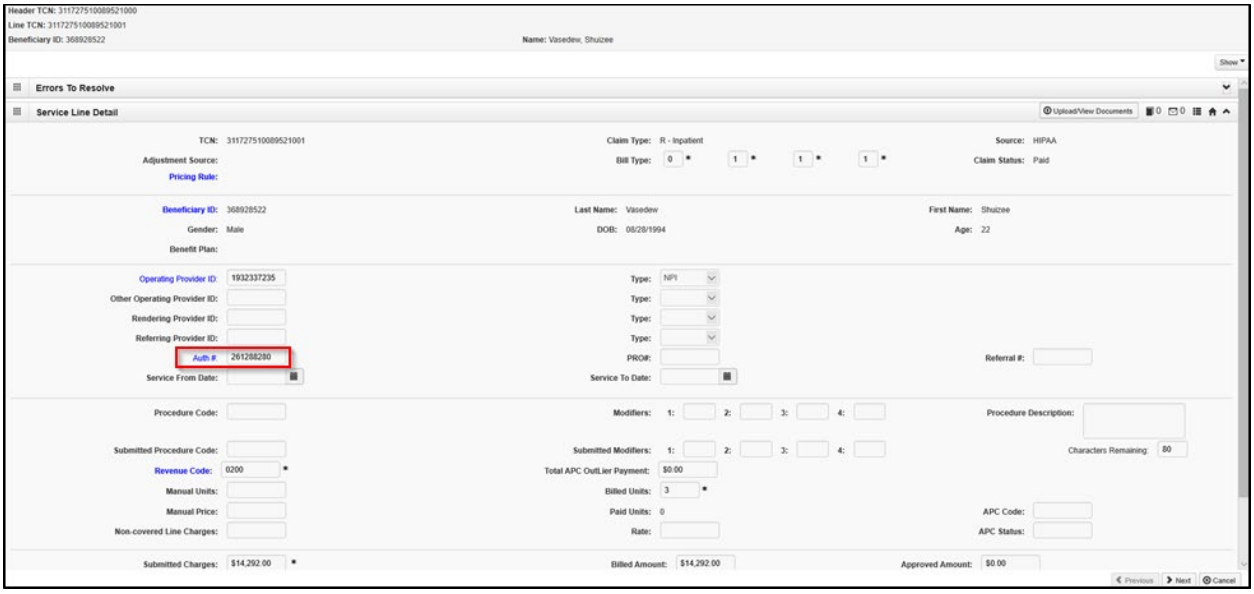


Figure 3.10.10-124 Claims Inquiry - Prior Authorization. Users have the ability to view claims transaction data and service utilization information online.



Figure 3.10.10-125 Service Authorization from Claims Record. Hyperlinks within the Service Authorization from Claims Record provides users with a quick way to obtain prior authorization details.

3.10.11 Pricing and Payment

This section addresses claims pricing and payment requirements. The solution will accurately calculate and price using applicable reimbursement methodologies for services, including but not limited to, fee for service, percent-of-charges, Resource-Based Relative Value Scale (RBRVS), Diagnosis Related Groups (DRG), Ambulatory Payment Classification (APC), Prospective Payment System (PPS), Relative Value for Dentists (RVD), laboratory and x-ray services, and negotiated rates including encounter and capitation fees. The solution must also be flexible to ovations with the ability to model proposed changes to identify impact and risk. Additionally, the solution must manage health insurance premium payments (HIPP) and other payment processes for Medicare programs. The Offeror must describe in detail their approach to meet each of the Pricing and Payment requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Pricing Approach

The evoBrix X CPMS solution leverages the real-time claims pricing rules engine of the evoBrix X Core Claims module powered by the RuleIT™ platform coupled with configurable rate setting, eligible benefits definition. The evoBrix X Core Claims module includes multiple pre-defined rules of standard pricing methodologies, which includes inpatient pricing (All Patients Refined Diagnosis Related Groups [APR-DRG], provider pre-diem), outpatient pricing (Outpatient Prospective Payment System [OPPS], Ambulatory Patient Group [APG], ambulatory payment classification [APC]), fee schedule-based pricing, relative value pricing, prior authorized service pricing, Ambulatory Surgical Center (ASC) pricing, Health Insurance Premium Payment (HIPP) and time value base pricing. In addition, the evoBrix X Core Claims module can be configured to support additional Department of Public Health and Human Services (DPHHS)-specific pricing based on rules and regulations.

The Team CNSI Advantage

The evoBrix X Core Claims Module provides a comprehensive pricing solution powered by RuleIT™ rules engine predefined with standard pricing methodologies, Benefit Administration and Rate Setting subsystems with flexibility to extend pricing rules as per agency's pricing methodologies.

- Predefined pricing methodologies include inpatient pricing (APR-DRG), outpatient pricing (APG, OPPS), fee schedule pricing, relative value-based pricing, clinic pricing (FQHC, RHC, IHSp), time calculation pricing
- The Benefits Administration, Reference and Rate Setting subsystems provides flexibility to configure benefit programs, pricing hierarchies and specific pricing decision matrices, maintain fee schedule with multiple rate definition based on claim factors
- Capable of performing pricing review and auditing of priced claims
- Team CNSI's solution provides fully traceable payment transactions including HIPP payment, lump-sum payments (GA) and reporting in remittance advice

MTCPM-1.2.4-539

The key aspects of the evoBrix X Core Claims module's pricing components include:

- Team CNSI developed pricing rules and algorithms based on the RuleIT platform's rules engine, which is de-coupled from our solution to provide flexibility related to maintenance and change control.
- Our solution calculates payments for institutional, professional, dental, and crossover claims using a variety of pricing methodologies, including Fee-for-Service (FFS) and encounters.
- Our solution supports multiple standards and DPHHS-specific pricing methodologies, including those listed above, which address cost to charges ratios, lab panels, ambulatory surgical centers, anesthesia, newborn, and trauma claims and encounter pricing.
- Our solution applies a business flow sequenced to address the pricing process, which provides flexibility and agility to accommodate DPHHS pricing policy changes.

Team CNSI currently maintains pricing files for the states of Michigan and Washington and applies established processes to manage the retrieval and loading of those files. We load DPHHS-provided pricing files into evoBrix X Core Claims module pricing tables. We offer established processes and procedures for file interchange activities, including file reconciliation practices, to verify that our solution correctly updates all records. Audit trails within the evoBrix X CPMS solution track updated details, including dates and times.

The pricing logics in the evoBrix X Core Claims module are well-articulated. Team CNSI also diligently maintains our solution by implementing and maintaining structured documentation practices, which we support with exhibits to further explain the payment methodology.

The evoBrix X Core Claims module also includes a flexible Reference and Benefits Administration sub-module to create different programs and build specific pricing decision matrices. Team CNSI handles these programs and benefit assignments through the maintenance of benefit plans, allowable limits, and code sets with pricing flags using application screens in the Core Claims module, which we will configure for the State of Montana Claims Processing and Management Services (MT CPMS) project. The evoBrix X Core Claims module encompasses rate (defined as code rates), a Relative Value Unit (RVU) with conversion factors, provider per-diem rates, member-specific rates, and a pricing hierarchy that we use to price claims and shadow price encounters. This ensures that Team CNSI prices claims that match benefits, provider contracts, and reimbursement methodologies per DPHHS requirements.

The evoBrix X Core Claims module calculates payments amounts for each service claim header and/or claim line based on data driven rules applicable to a claim's date(s) of service and benefit assignment applicable to the date(s) of services and related, but not limited to, the following indicators:

- Service type
- Pricing modifier
- Category of service
- Provider type, per DPHHS-defined program policy

The evoBrix X CPMS solution leverages pre-built pricing rules and applies them to various claims types to determine Medicaid allowable amounts, co-insurance, deductibles, and all pricing logics (e.g. "lesser of," co-pay, cutback) associated with a claim. Team CNSI computes pricing and payments for services according to DPHHS Medicaid Payment Policy and the provisions of 42 CFR 447.

The RuleIT platform verification and validation process precedes the claims adjudication pricing phase. The key aspects of this process include:

- Claims go through a series of edits in the RuleIT platform orchestrated by grouping of edit categories
- The RuleIT platform executes rules through a sequential flow, which decision rules in the flow can alter

The versatile RuleIT platform can also reference another set of rules within a set. For instance, we designed the evoBrix X Core Claims module to accommodate configuration for "lesser of" pricing logic, so that the final reimbursement amount posted on a claim is the lower of either the provider claim charge or the amount per the applicable Medicaid fee schedule. Team CNSI can apply this to any service type, including ambulance, home health, laboratory, dental, or any services delivered under waiver programs. These features facilitate reusability of validations, edits, and the design of complex rules.

In instances when DPHHS directs Team CNSI to manually price claims, we configure edits in the following steps:

1. evoBrix X Core Claims module suspend claim for manual pricing
2. Team CNSI claims processer apply DPHHS instructions to manually price the service
3. If any fee or pricing-related issues are discovered during adjudication, such as coordination of benefits (COB) or DRGs, the claim is again suspended for manual review
4. Team CNSI business analysts receive these types of pricing-related suspensions for further research and resolution.

These controls ensure that Team CNSI does not price claims manually without appropriate authorization. This, in turn, results in accurate claims pricing for DPHHS and establishes reliable claims payments for the provider community.

Team CNSI has provided responses to each of the Attachment F requirements including screenshots where appropriate to illustrate the available functionality.

PP01

The Contractor's solution shall store, on the header and/or each claim line, the claims payment methodology used to adjudicate the respective header and/or claim line.

The evoBrix X Core Claims module stores key data elements derived during the adjudication process. Our solution uses a pricing methodology data element to determine a claim payment at the header or claim line per established pricing rules, which are based on invoice and claim types.

Inpatient, Outpatient Prospective Payment System (OPPS), and State Psych claim types on institutional invoices display at the header level based on a header level pricing methodology (as shown in Figure 3.10.10-1. Other claim types display at the line level based on a line level methodology (as shown in Figure 3.10.11-2).

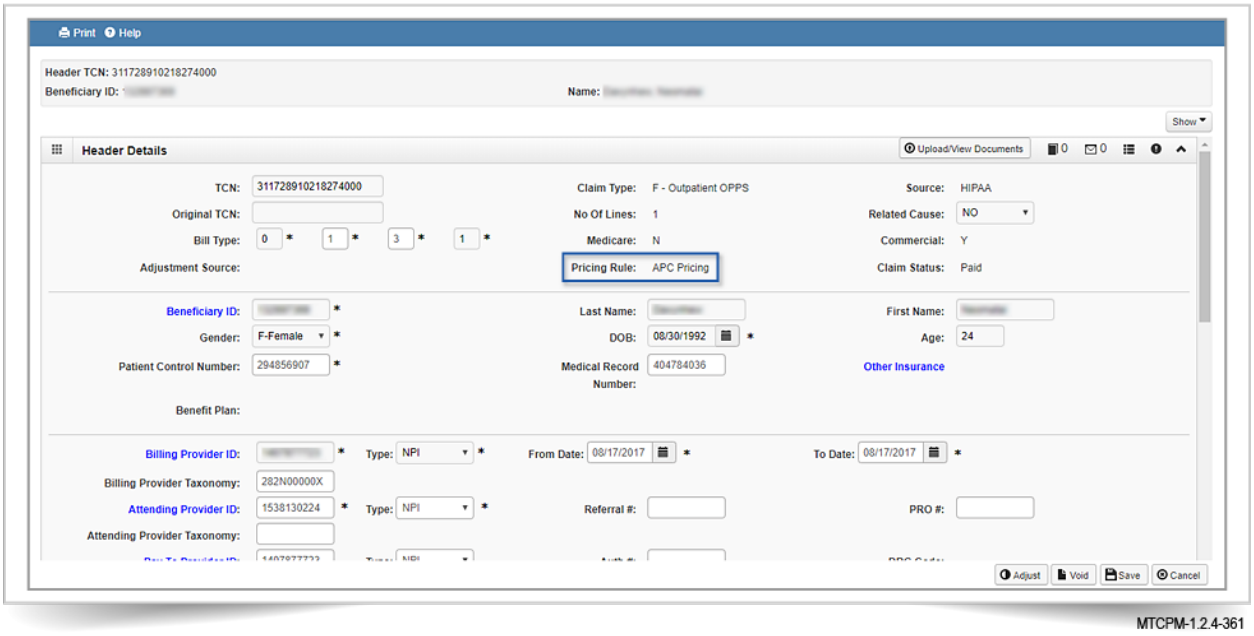


Figure 3.10.11-1. Claim Header Detail screen with pricing rule information.

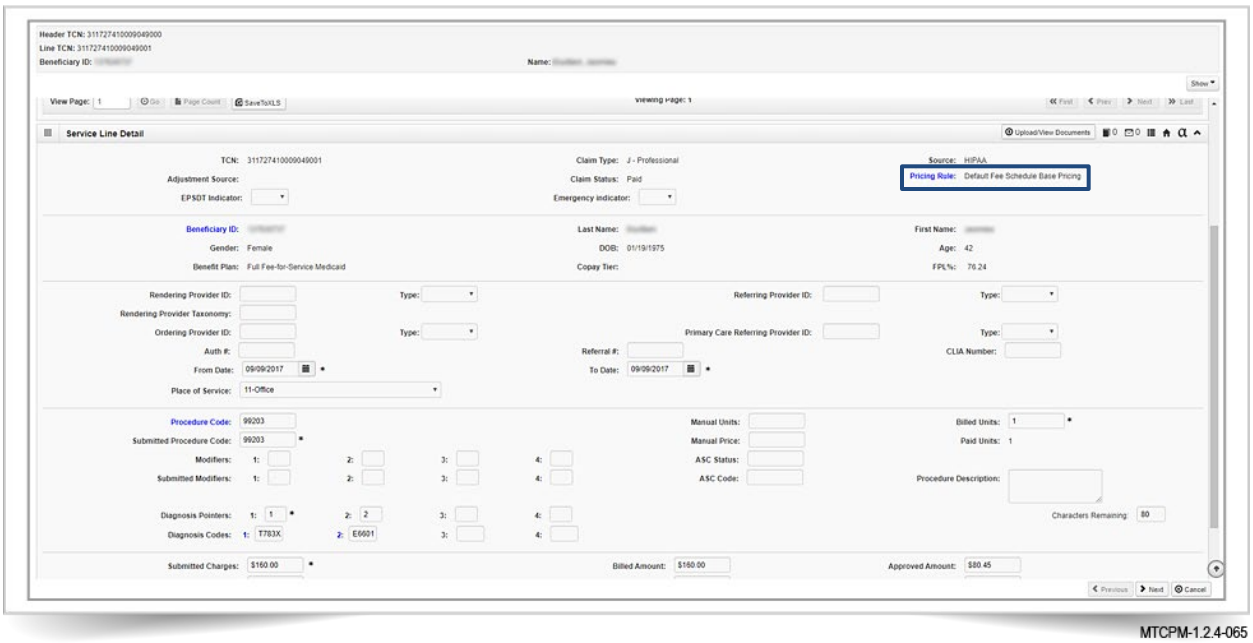


Figure 3.10.11-2. Claims Line Detail screen with pricing rule information.

PP02

The Contractor's solution shall provide a configurable hierarchy of pricing and reimbursement methodologies determined by the Agency.

The evoBrix X Core Claims module provides a configurable hierarchy of pricing and reimbursement methodologies, which authorized users use to price services (as shown in Figure 3.10.11-3). When multiple pricing methodologies are available for a procedure code that is based on claim type and available priority our solution determines pricing for a claim header and/or claim line

During claims adjudication, Team CNSI will need to customize our solution to configure the pricing hierarchy to determine the appropriate pricing methodology to be applied based on claim type and ascending order of priority. Pricing for CBSA, LOC, Member, Provider, and Specialty Rates all take precedence over code rates and Team CNSI can customize these pricing hierarchies and reimbursement methodologies per DPHHS needs.

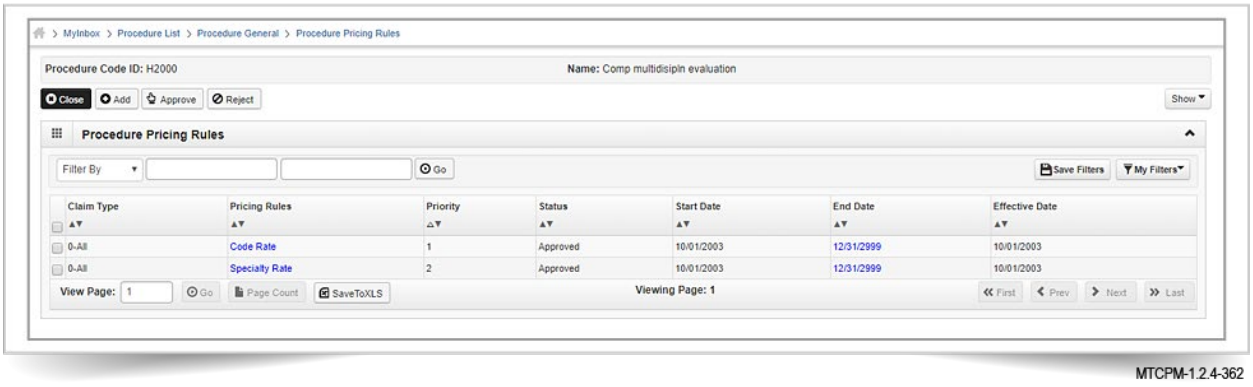


Figure 3.10.11-3. Pricing Hierarchy Configuration screen where users price services.

Based on Agency requirements, we can define new pricing rule hierarchies using the configuration screen depicted in Figure 3.10.11-4.

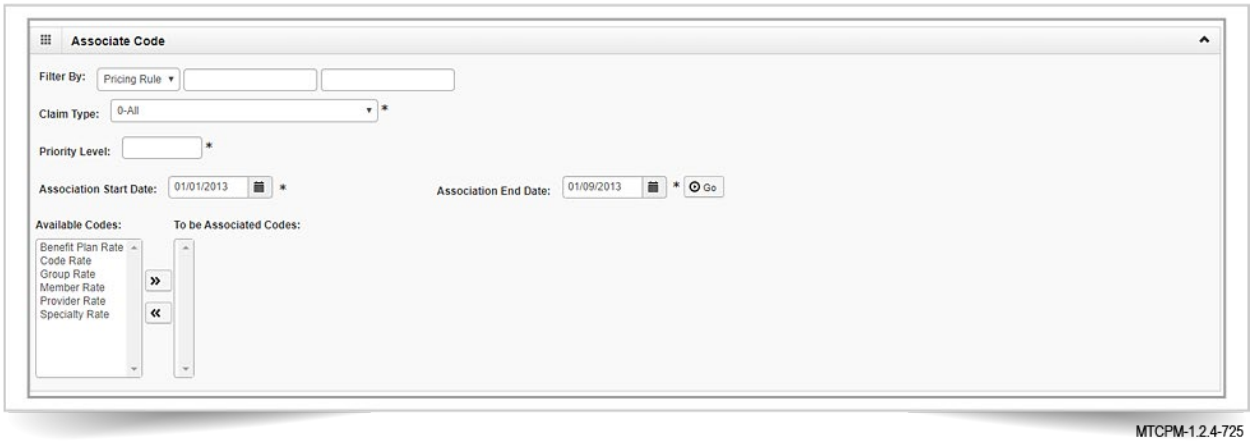


Figure 3.10.11-4. New pricing rule hierarchies can be defined using this screen.

PP03

The Contractor's solution shall accept and process Medicare crossover claims using Medicare coinsurance and deductible amounts on the coordination of benefits segment/s using Agency configurable rules (e.g., claim type, provider type, benefit package, age, Medicare coinsurance, Medicare Deductible, Medicaid allowed, etc. with Medicaid as the payer of last resort).

The evoBrix X Core Claims module accepts and process Medicare crossover claims. Our solution includes pre-defined Medicare crossover claims pricing rules in the RuleIT platform to edit and determine payable amounts. The RuleIT platform uses Medicare allowed amounts, paid amounts, coinsurance, and deductible data to determine member liability on a Medicare payment. The RuleIT platform will then determine the Medicaid-allowed amount for billed services and determine the Medicaid payable amount using the lesser of the Medicare Member liability, Medicare allowed amount, and Medicaid allowed amount. We can configure these rules to handle Agency-specific pricing requirements using claim type, provider type, benefit package, and member age. Authorized users can view the Medicare and Medicaid amounts as shown in Figure 3.10.11-5.

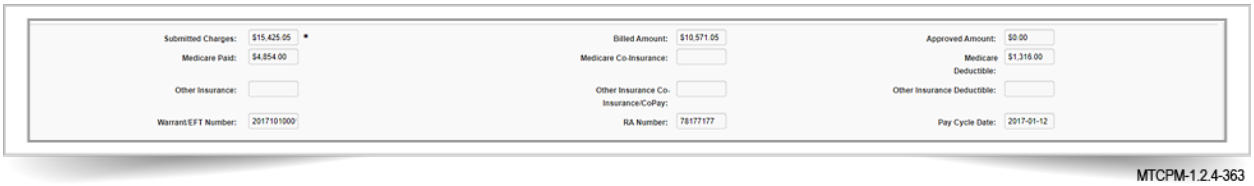
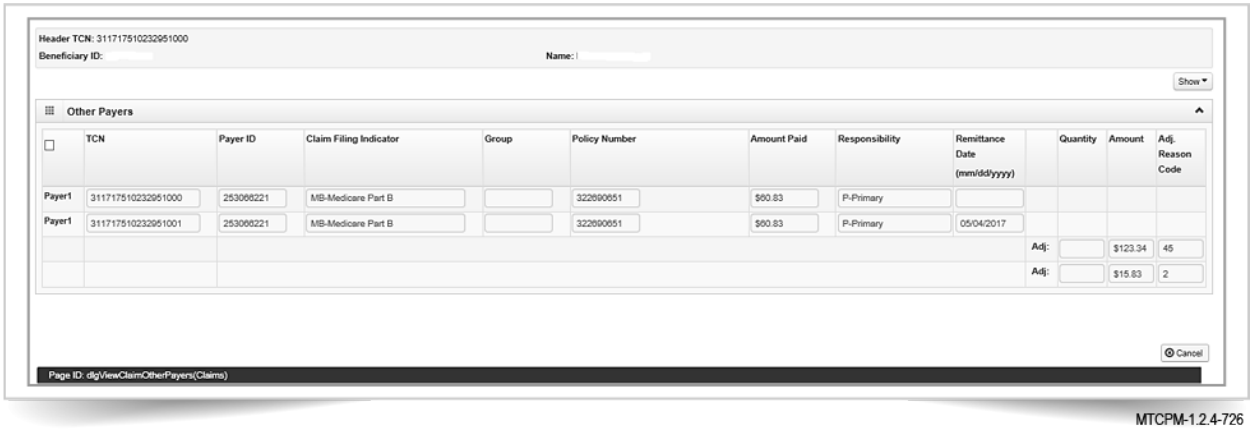


Figure 3.10.11-5. Authorized users view Medicare and Medicaid amounts on this screen.

Figure 3.10.11-6 shows Medicare co-insurance and deductible amounts.



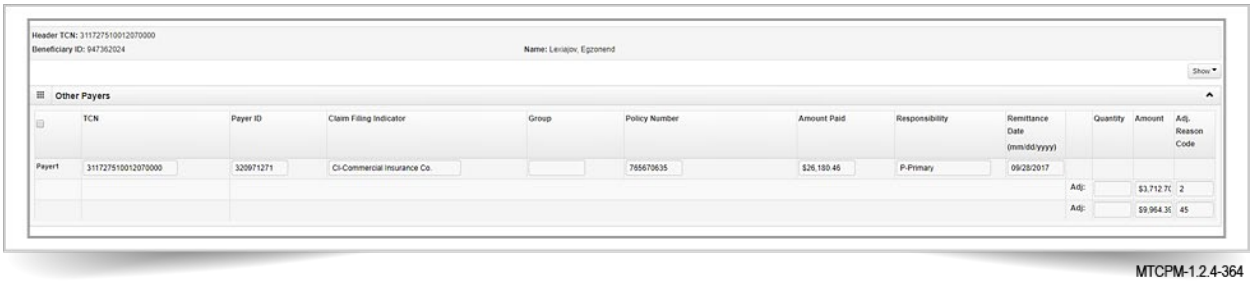
MTCPM-1.2.4-726

Figure 3.10.11-6. Our solution receives Medicare crossover claims in paper and 837 electronic transaction files, as well as via the DDE/web screens.

PP04

The Contractor's solution shall ensure all applicable third-party payment information is captured, stored, applied, and reported based on Agency configurable business rules.

Team CNSI designed the evoBrix X Core Claims module to capture, store, maintain, and report third party benefit determinations as Other Payer information on claims. Customization will be necessary, however, to integrate the TPL file through the MPATH System Integrator, adhering to pre-defined DPHHS rules to allow authorized users to apply a COB when processing claims, which includes third party payments through the Other Payer Information screen shown in Figure 3.10.11-7.



MTCPM-1.2.4-364

Figure 3.10.11-7. Users apply a COB when processing claims through this screen.

PP05

The Contractor's solution shall identify claims applicable for drug rebate processing and post appropriate claim edits in accordance with 42 USC 1396r-8 PAYMENT FOR COVERED OUTPATIENT DRUGS (e.g., Medicare crossover, physician administered drugs), store a drug rebate indicator, and transmit the required data to the appropriate system.

Team CNSI designed the evoBrix X Core Claims module to accept HCPCS-NDC crosswalk drug files from the Pharmacy Benefit Management System (PBMS) as batch interface files through the Interface Service Repository (ISR) component. Customization will be necessary, however, to integrate the DUR file with the PBMS through the System Integrator. We process, store, and maintain the files, including the drug rebate indicator, in the evoBrix X Core Claims module.

Pre-defined rules within the RuleIT platform enable us to adjudicate physician-administered drugs and Medicare Crossover claims with J-Code procedures using PBMS drug files in accordance with 42 USC 1396r-8. Our solution identifies and transmits the required data to the applicable system for drug rebate processing and posts appropriate claim edits using the National Drug Code detail screens shown in Figure 3.10.11-8, Figure 3.10.11-9, and Figure 3.10.11-10.

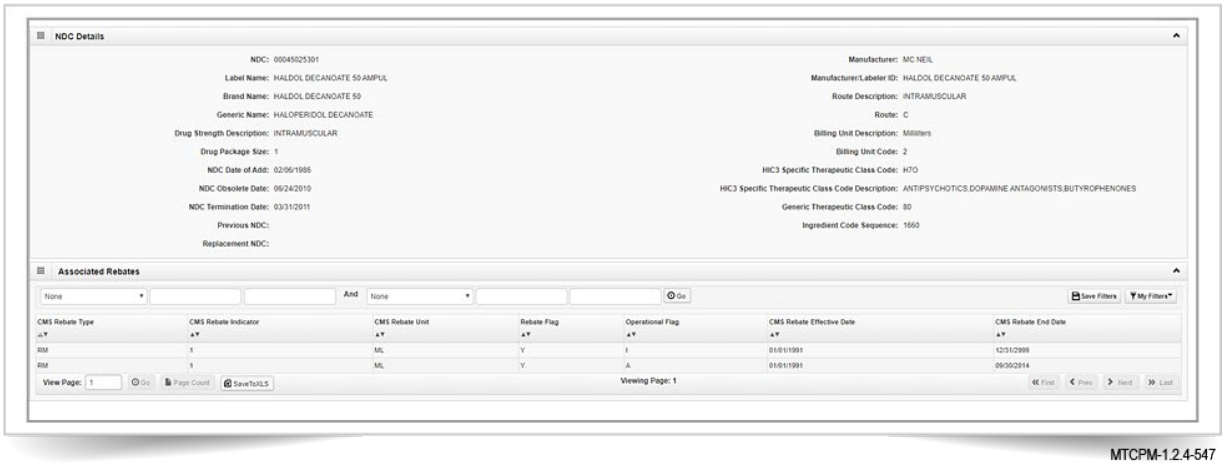


Figure 3.10.11-8. National Drug Code detail screen displaying drug rebate flags.

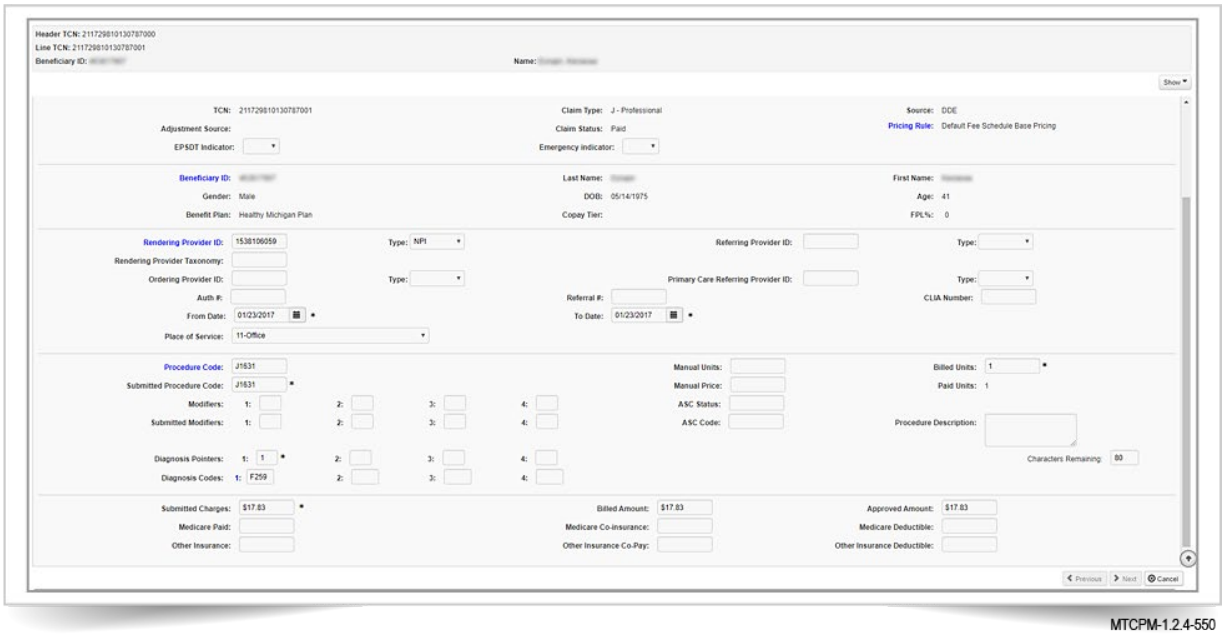


Figure 3.10.11-9. National Drug Code detail screen displaying a J-Code priced using a drug fee schedule.

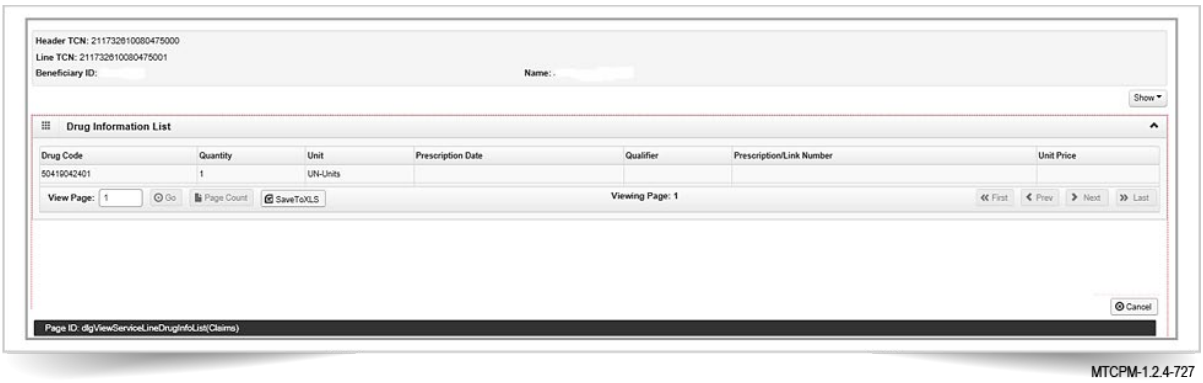


Figure 3.10.11-10. National Drug Code detail screen displaying service claim line details with a J-Code.

PP06

The Contractor's solution shall reimburse providers based on Medicare's Outpatient Prospective Payment System (OPPS), based on Agency configurable business rules (e.g., Ambulatory Surgery Center, Hospital Outpatient, Comprehensive Outpatient Rehabilitation Facility (CORF)).

Team CNSI designed the evoBrix X Core Claims module to reimburse providers based on Medicare's standard Outpatient Prospective Payment System (OPPS) using 3M™ Grouper Plus Content Services, which is a hosted solution that provides access to content through web-based services.

The evoBrix X Core Claims module adjudicates and prices outpatient claims at the line level through pre-defined editing functionality, and Team CNSI uses 3M Grouper services to price Ambulatory Surgery Center, Hospital Outpatient, and Comprehensive Outpatient Rehabilitation Facility (CORF) services, as shown in Figure 3.10.11-11.



Figure 3.10.11-11. This detail screen depicts Ambulatory Payment Classification codes.

PP07

The Contractor's solution shall provide a clinical claim editor (grouper) with the capability to price inpatient hospital services according to DRG methodologies defined by the Agency.

The evoBrix X Core Claims module processes and prices inpatient hospital services, including claims, using the 3M All Patients Refined Diagnosis Related Groups (APR-DRG) Grouper, according to DRG methodologies per DPHHS requirements. Our solution offers real-time integration with the 3M APR-DRG Grouper and returns DRG code, as shown in Figure 3.10.11-12.

Based on the DRG code, pre-defined rules within the RuleIT platform determine claims disposition. The RuleIT platform applies DRG rate factors (e.g. DRG code, relative weight, low day, high day, percentage of charge) and provider DRG factors (e.g. DRG base rate, operating ratio skilled days rate) when determining a claim's payable amount.

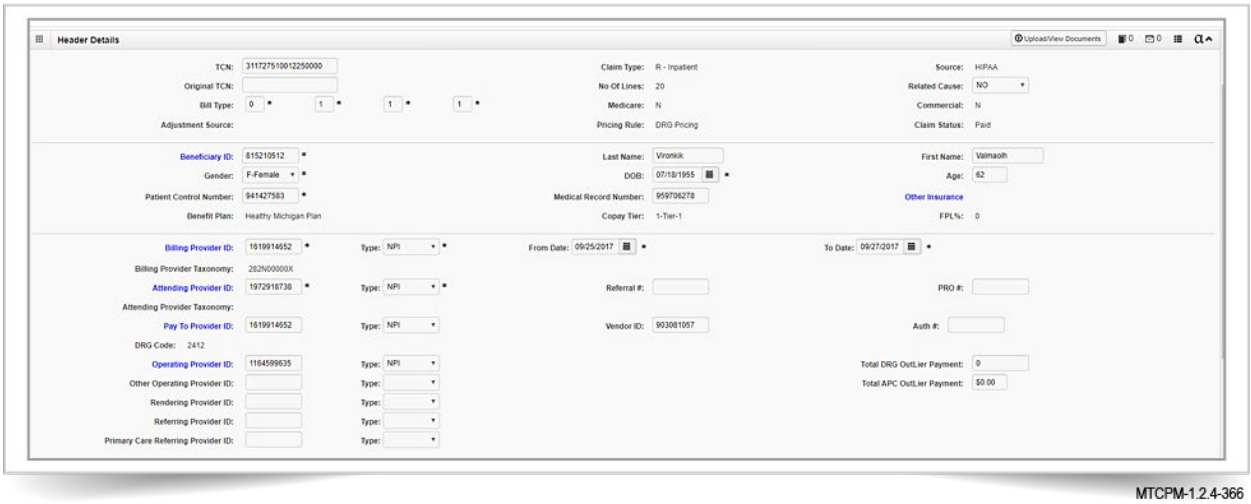


Figure 3.10.11-12. Claim header detail page with DRG code returned from grouper.

PP08

The Contractor's solution shall obtain transportation documentation via interface from the Agency's Ambulance Trip Reporting System and store the documentation associated with the claim in order to fully adjudicate ambulance transportation claims.

Team CNSI's evoBrix X CPMS solution includes an ISR component, which allows users to add, manage, and monitor interfaces. In addition, the integration services also provide the ability to accept files using ESB-defined service points. Team CNSI will customize our solution to establish an interface with the Agency's Ambulance Trip Reporting System to receive a batch interface with electronic ambulance trip records (documentation). We will store these records with an associated claim matched to a provider, member, and service date. Our solution validates claim service line with the trip record to fully adjudicate ambulance transportation claims.

PP09

The Contractor's solution shall allow for configurable claim copays and/or cost-share assessments (e.g., benefit plan, age, claim type, service, provider, race, IHS utilization, nursing home residents, household limits by time period, and cost-share coordination) as defined by the Agency.

The evoBrix X Core Claims module includes a configurable definition for co-pay/cost share amounts needed for multiple member eligibility group assessments per DPHHS requirements. We define co-pay and cost shares based on benefit plans, service types, and Federal Poverty Line (FPL) tiers with applicable restrictions based on a member's age range, Native American status, race, and level of care amongst other variables. Our solution can apply co-pay and cost share on claims, and bypass that information once a cost share limit is reached.

Users can access this information through the Cost Sharing Configuration screen, shown in Figure *3.10.11-13*.

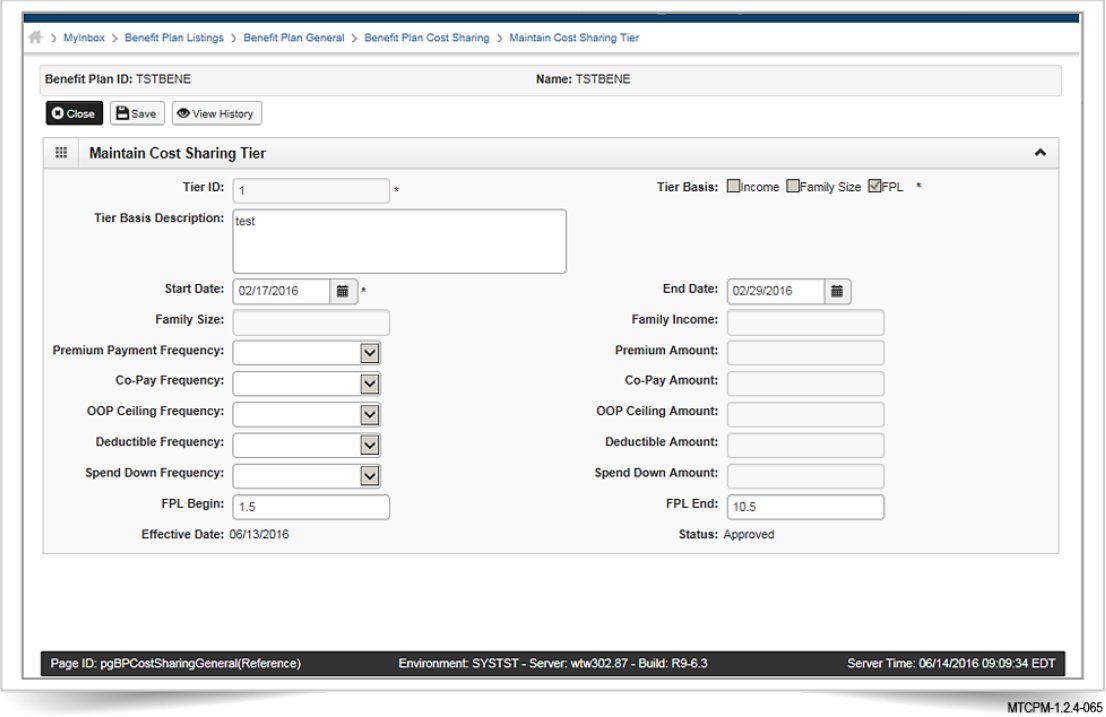


Figure 3.10.11-13. Cost Sharing Configuration screen where users can apply co-pay and cost share on claims.

PP10

The Contractor's solution pricing process shall establish the allowed amount of the claim prior to member copay and/or cost-share amount.

The evoBrix X Core Claims module rules engine defines pricing rules by claim type, which allows Team CNSI to apply claim header or claim line level pricing based on a specific pricing methodology. The pricing business flow allows an amount to be derived based on the billed services, which are direct rates from the fee schedule and the provider contract rates.

Any deduction related to member responsibilities (e.g., co-pay, deductibles, and cost-sharing) are applied during the post computation of allowed amounts and final paid amounts and include any rate reductions (e.g., specialty, modifier reduction program, or plan-defined reductions). This ensures that the evoBrix X Core Claims module establishes the allowed amount of a claim prior to the member co-pay or the cost-share amount.

PP11

The Contractor's solution shall capture, store, maintain, and report deductibles, copay, and coinsurance paid by member and benefit plan and/or program type.

The evoBrix X Core Claims module determines copay, coinsurance, and deductibles based on a member's benefit plan and cost share spending limits. Pre-defined rules within our solution determine member liability and Team CNSI captures, stores, maintains, and reports that information with a claim.

We store member liability deducted from a claim in an accumulator table. Our solution evaluates the cost share limits and posts edit based on the "Cost Share Met" flag when a member meets their cost share limit (as shown in Figure 3.10.11-14). Once a limit is met, no member liability is deduced from subsequent

claims until the flag is reset for the next assessment period. Figure 3.10.11-15 displays when our solution applies a co-pay to a claim.

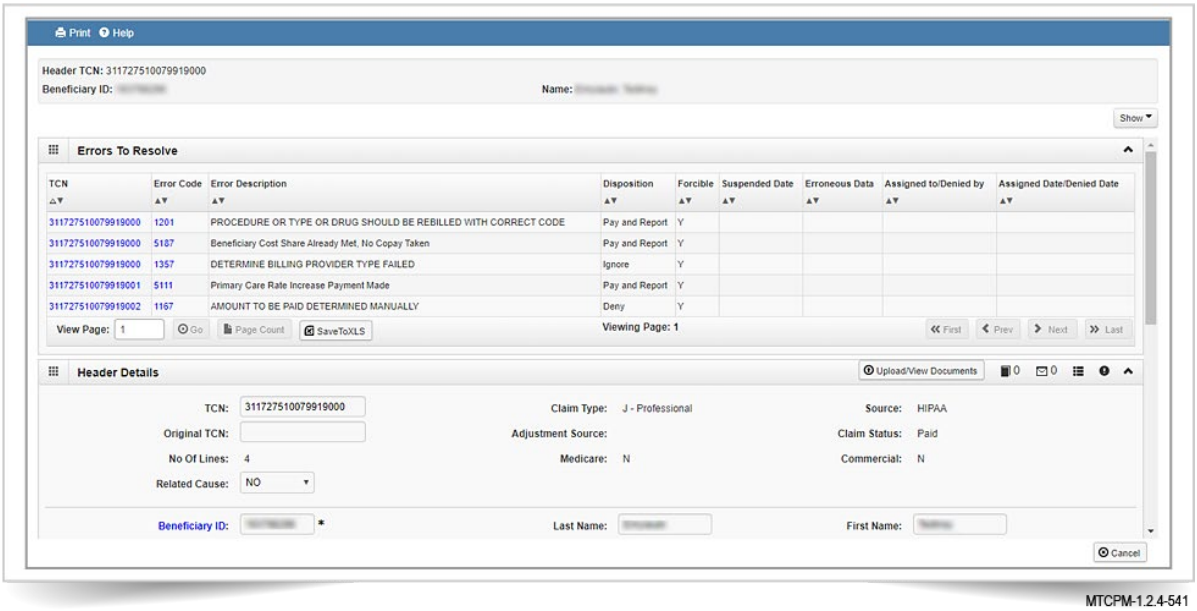


Figure 3.10.11-14. This screen displays post header edits to denote that member cost share has been met.

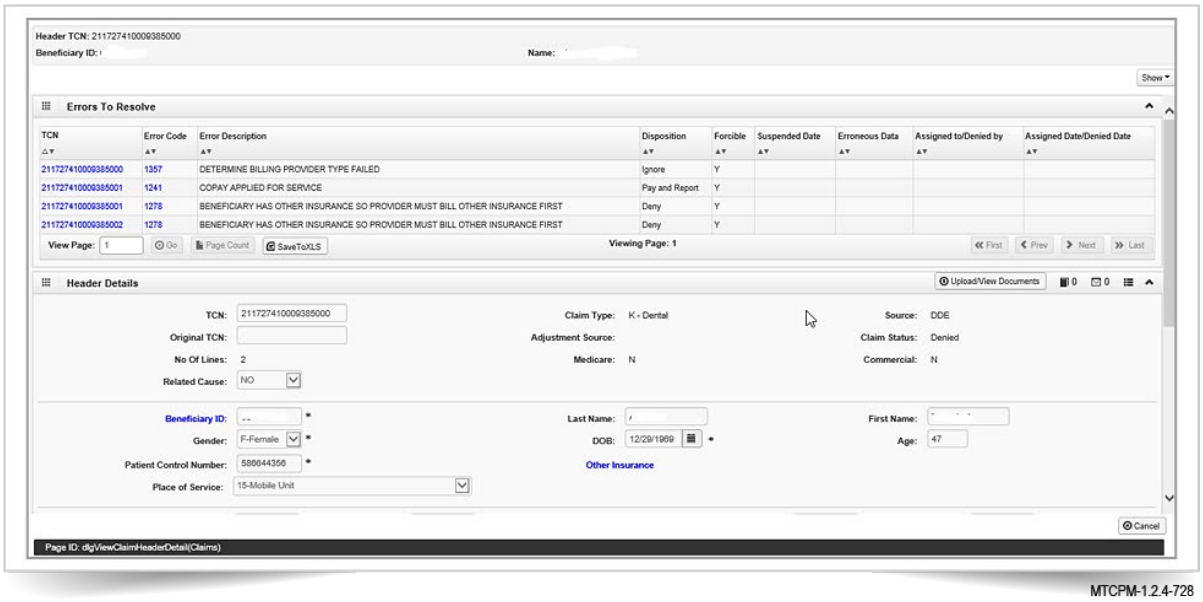


Figure 3.10.11-15. This screen indicates that a co-pay has been applied on a claim.

PP12

The Contractor's solution shall have the ability to capture, store, report, and apply multiple third-party payments (e.g., primary, secondary, tertiary) to a single claim in the order indicated on the TPL data source.

The evoBrix X Core Claims module captures, stores, reports, and applies multiple third-party (TPL) payments (e.g., primary, secondary, tertiary) reported on claim. The RuleIT platform's pre-defined rules process a claim by applying TPL payment details. The RuleIT platform then applies the COB and

determines the Medicaid payable amount using "lesser off" logic, factoring in the member's responsibility, as shown in Figure 3.10.11-16 and Figure 3.10.11-17.

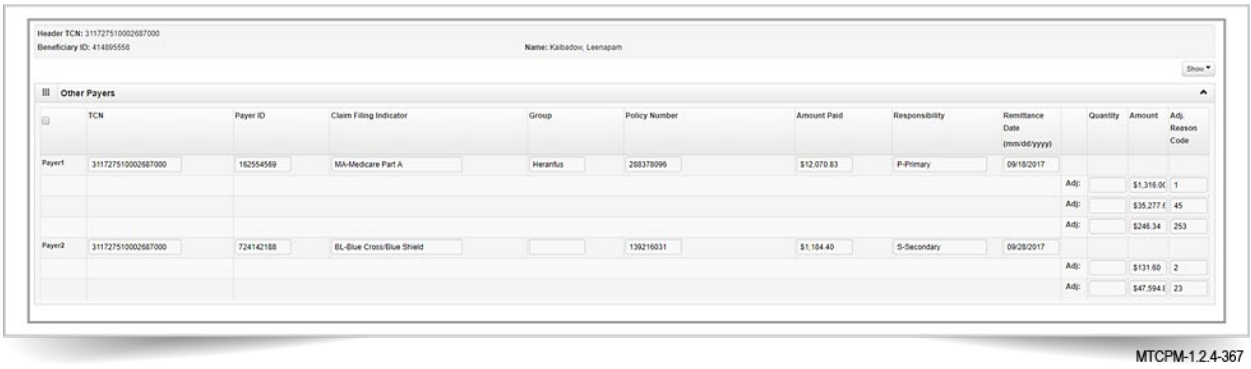


Figure 3.10.11-16. The TPL Information screen displays relevant information on COB payments.

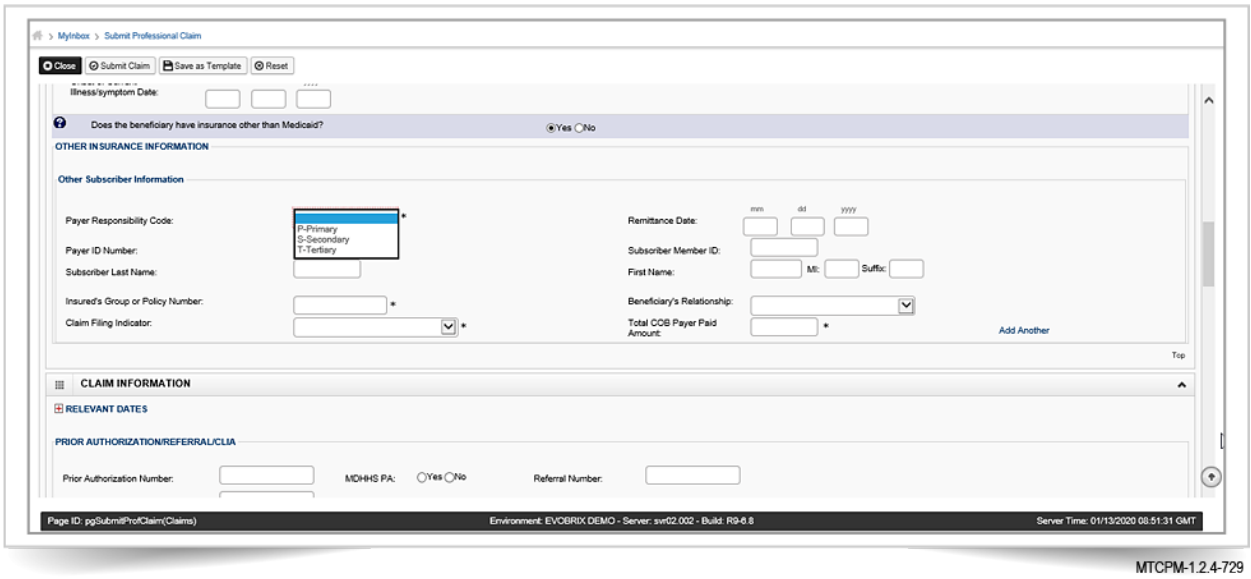


Figure 3.10.11-17. Our solution can capture and store multiple third-party payments (e.g., primary, secondary, tertiary) to a single claim.

PP13

The Contractor's solution shall accept member liability (e.g., Spenddown, nursing home, maximum out-of-pocket, cost-share coordination). information from relevant source(s) (e.g., eligibility, financial) and apply configurable business rules to deduct the liability from the appropriate claims.

The evoBrix X CPMS solution receives member liability information (e.g., spend down, nursing home, maximum out-of-pocket, cost-share coordination) from external sources (e.g., eligibility and financial) through the ISR process. The liability information is then stored with the member record.

The pre-defined rules in the RuleIT platform applies respective member liabilities based on the claim being processed and tracks the applied liabilities in member cost share tables. We apply configurable business rules when deducting the liability from the appropriate claim, as shown in Figure 3.10.11-18. Providers are responsible for collecting the patient pay amount for each calendar month for nursing homes, hospice facilities, and inpatient hospitals.

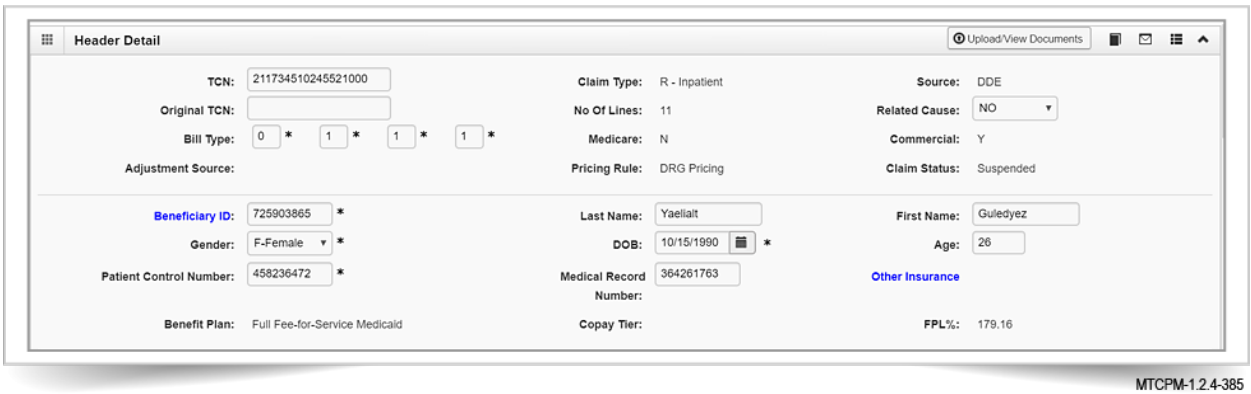


Figure 3.10.11-18. The FPL% Information screen displays relevant member liability information.

We pre-configured our solution with spend-down editing and accumulation processing capabilities. Spend-down amounts are the difference between member income and the Medicaid eligibility limit, as determined by DPHHS over an established eligibility span period. Spend-down works almost like a deductible: A member is responsible for paying certain portion of claims as determined by DPPHS over an eligible span period. Once the member spend-down amount is met for a specific span period, then Medicaid pays the remaining portion of the claim. When a spend-down is applied to a claim, the evoBrix X Core Claims module sets an edit as shown in Figure 3.10.11-19 and maintains the member, dollar amount accumulated toward the spend-down amount, and all claims applied to the spend-down amount for each eligibility span period.

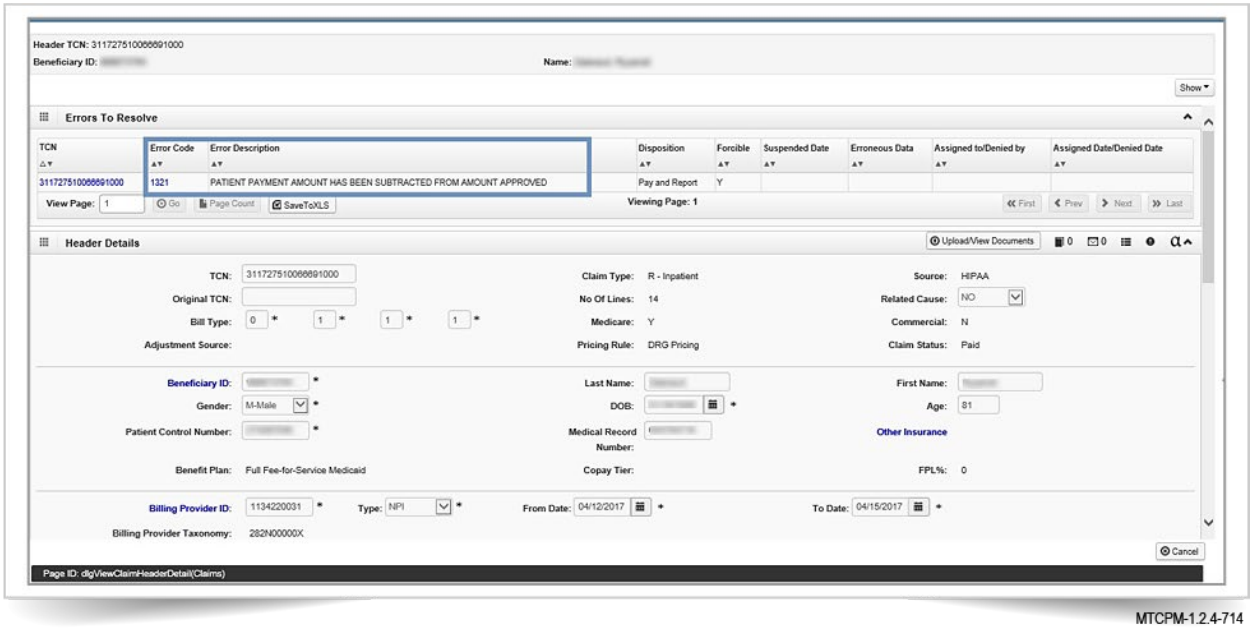


Figure 3.10.11-19. Error Disposition. Our solution provides flexible and configurable edit processing capabilities to activate or inactivate any pre-configured edits for claims processing. As shown, the evoBrix X Core Claims module sets edit 1321 when spend-down is applied to a claim.

PP14

The Contractor's solution shall track copays applied and/or credited for each assessment period.

The evoBrix X CPMS solution applies member liability like copay, patient pay, and premiums for benefit service packages for each assessment period. Rules engines apply member co-pays while pricing a claim.

All member liability amounts are loaded to an accumulator table. An automated process evaluates the cost share limits for each assessment period.

Once a member meets the 5% cost share limits, our solution establishes a "Cost Share Met" flag. Once the member meets cost share limits for the assessment period, our solution deducts no further member liability. Our solution re-sets the flag for the next assessment period post after it deducts the member liability, as show in Figure 3.10.11-20.

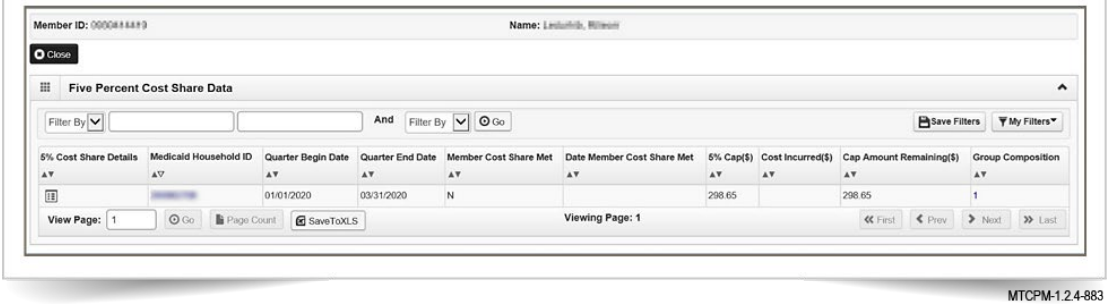


Figure 3.10.11-20. Cost Share Data History screen that shows when a flag is re-set for the next assessment period following a member liability deduction.

PP15

The Contractor's solution shall notify the provider of cost sharing deducted from each claim (e.g. EOB, CARCs, RARCs, remittance advice (RAs)).

Team CNSI designed the evoBrix X Core Claims module stores the member liabilities (e.g., co-pay, co-insurance, deductible) deducted from the allowed amount for a claim. Our pre-defined solution reports member liability at the claim header or claim line level as applicable. This information, along with the applicable Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) will be displayed on the generated Remittance Advice (RA) both in PDF format and X12 835 transactions. Figure 3.10.11-21 and Figure 3.10.11-22 shows a sample RA generated by our solution.

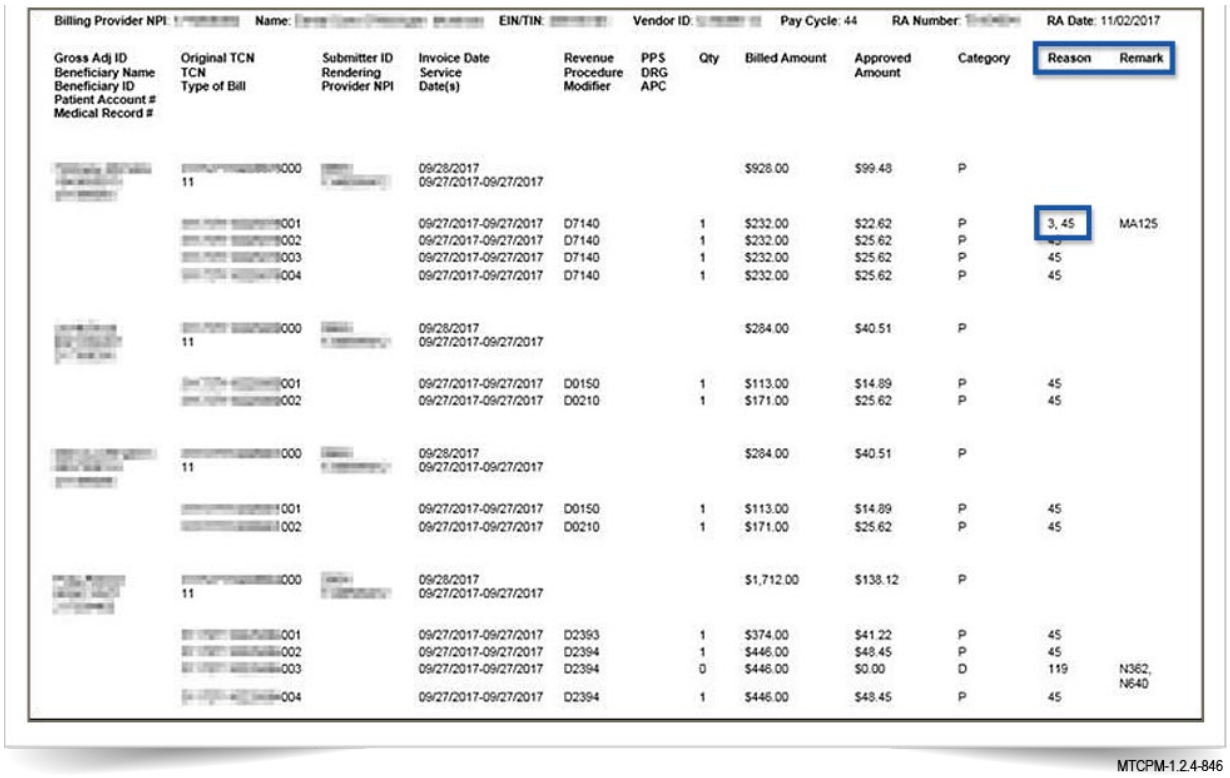


Figure 3.10.11-21. A sample RA containing cost share details.

The values in the "Reason" column represent CARC values and the values in the "Remark" column represent RARC values. The relevant CARC values relating to member cost share are:

1 – Deductible Amount
2 – Co-insurance Amount
3 – Co-payment Amount

The above contains one instance of a CARC value of 3.

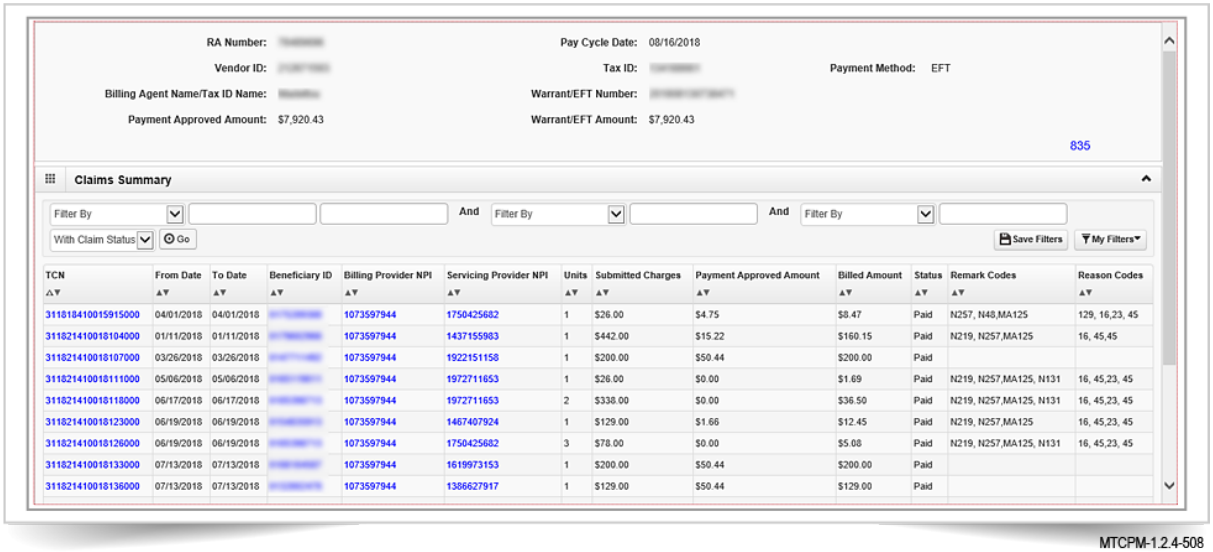


Figure 3.10.11-22. A sample RA that includes adjudication results.

PP16

The Contractor's solution shall provide the capability to view and maintain cost share information (e.g., maximum out of pocket, cost share) and generate notification as specified by the Agency.

The evoBrix X Core Claims module includes web screens, including the Cost Share Data History screen, shown in Figure MTCPM-1.2.4-070, for authorized users to view and maintain cost share information (co-pays, co-insurance, deductibles, premiums). Authorized users can also view summaries of the cost share's performance over designated assessment periods.

Our solution generates correspondence to notify members and households once cost share is met for a designated assessment period. Our solution maintains all cost share details for a beneficiary as well as for a household for each quarter. In addition, our solution associates a Cost Share Met Date for a given quarter when applicable.

Figure 3.10.11-23 displays benefit plan level cost share master data.

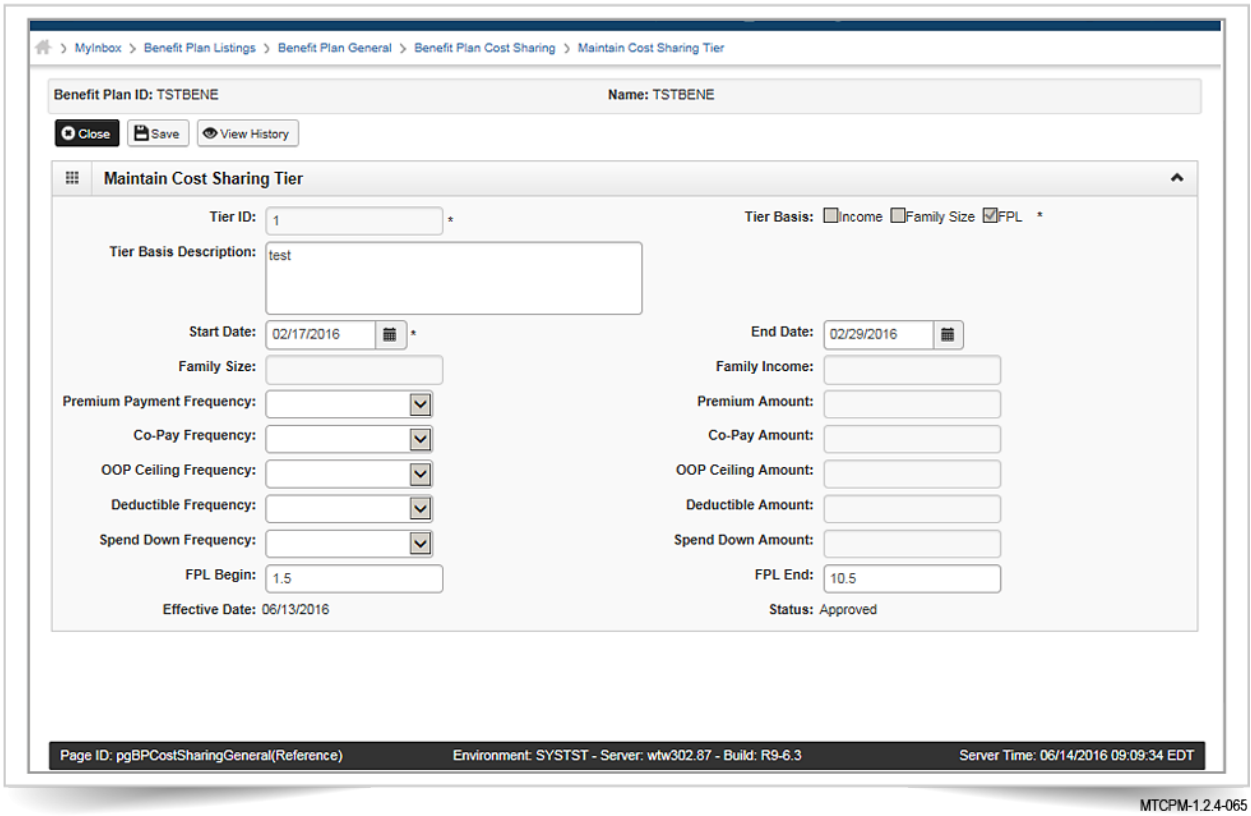


Figure 3.10.11-23. Cost Sharing Configuration screen that displays benefit plan level cost share master data.

When a member and/or his household is assigned an evoBrix X Benefit Plan, the various attributes of the Benefit Plan including the cost share amounts are automatically assigned as well. As and when members contribute towards their per-claim cost share obligations, they move closer to fulfilling their overall cost share expectation for a given period. These details cannot be maintained online as the calculations happen automatically as part of Claims Processing. We depict the relationship between a household and its cost share in Figure 3.10.11-24 and Figure 3.10.11-25.

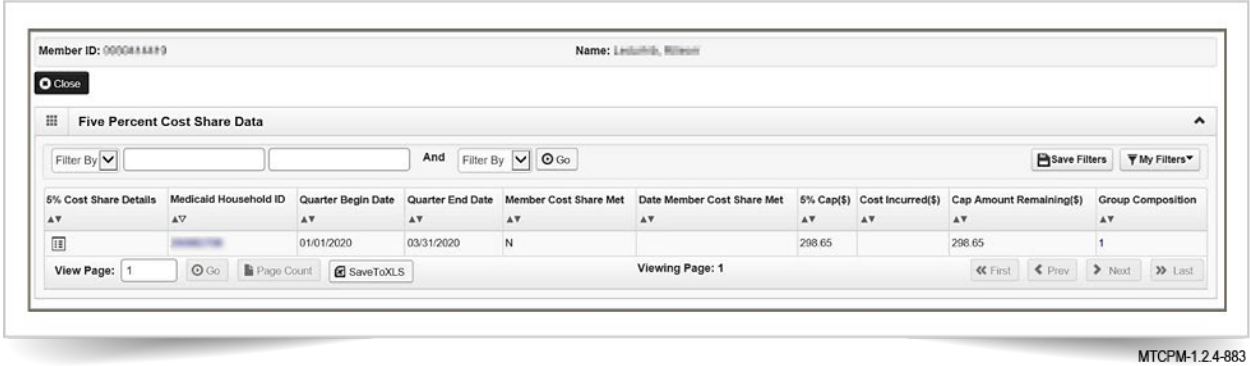


Figure 3.10.11-24. This screen displays cost share summary information for a household.

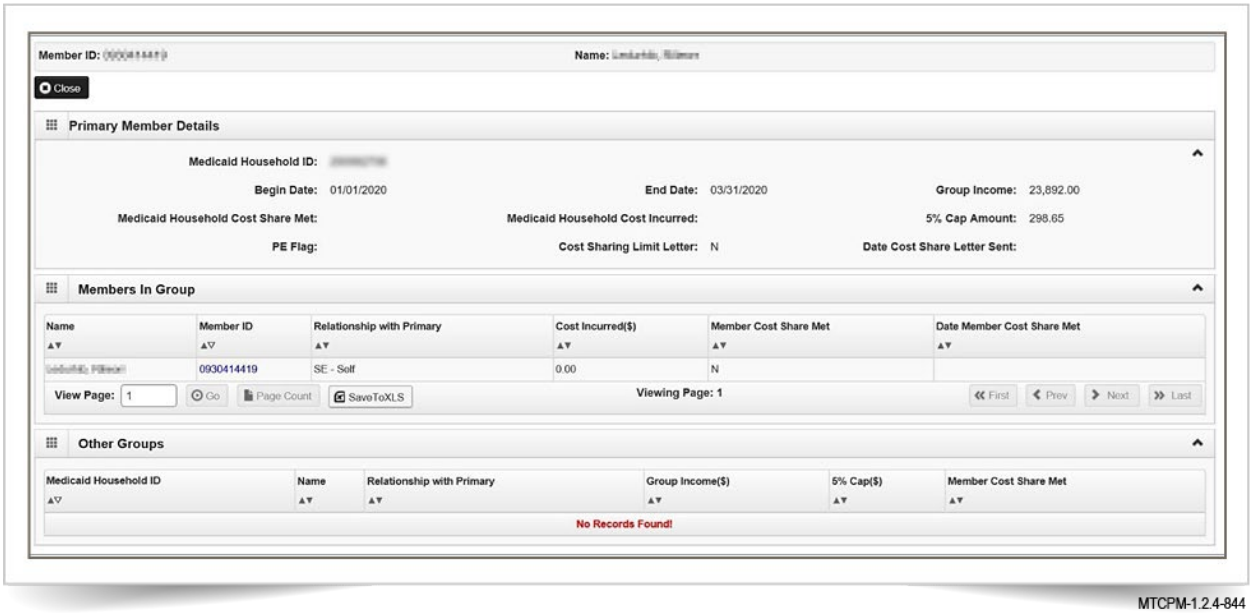


Figure 3.10.11-25. This screen displays cost share summary information for a household.

Our solution generates member correspondence to notify members and households once the cost share has been met for the designated assessment period. There is a field that tracks the date on which the Cost Share Letter was sent, as shown in Figure 3.10.11-24 above.

PP17

The contractor's solution shall track cost sharing applied and/or adjusted/voided/credited for each assessment period and create a new assessment period as defined by the Agency.

The evoBrix X Core Claims module includes two-step processing functionality to track member liability applied and/or adjusted/voided/credited for each assessment period, as shown in Figure 3.10.11-26 and Figure 3.10.11-27. In addition, our automated processes assess cost share utilization for each assessment period to establish a Cost Share Met Indicator and re-set the cost share utilization for each assessment period per DPHHS requirements.

For voids, if a member's cost share is not met within the same quarter, then our solution updates the member's current cost share utilization bucket with the void transaction co-pay amount. For adjustments, regardless if the member's cost share has been met, our solution updates the member's current cost share

utilization bucket with the adjustment transaction co-pay amount and the corresponding system-generated void transaction co-pay amount as well.

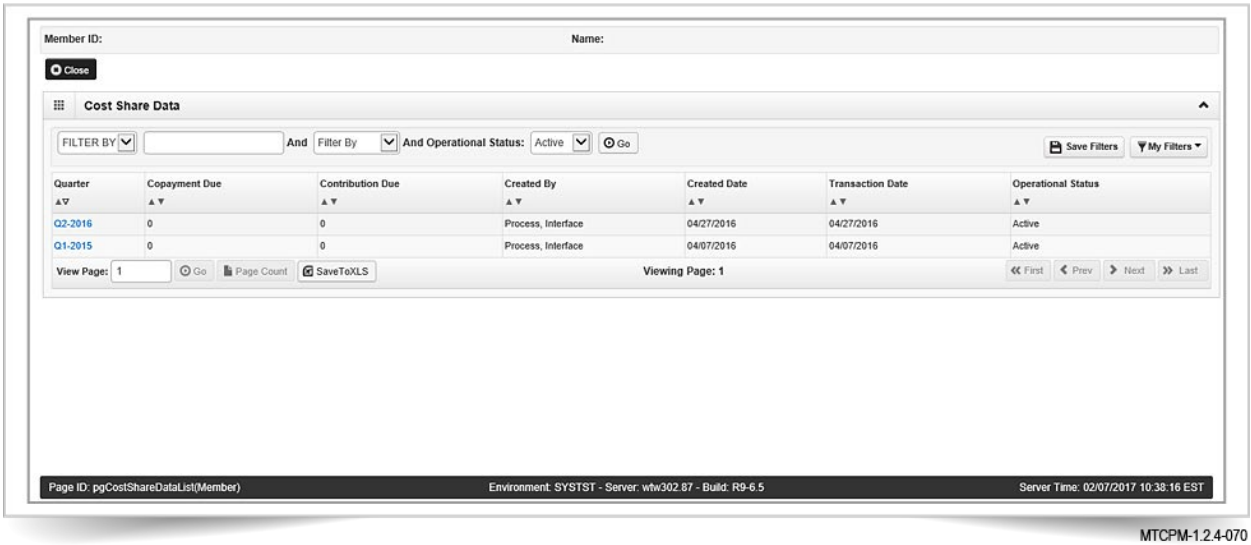


Figure 3.10.11-26. Cost Share Data screen where users can track member liability applied and/or adjusted/voided/credited for each assessment period.

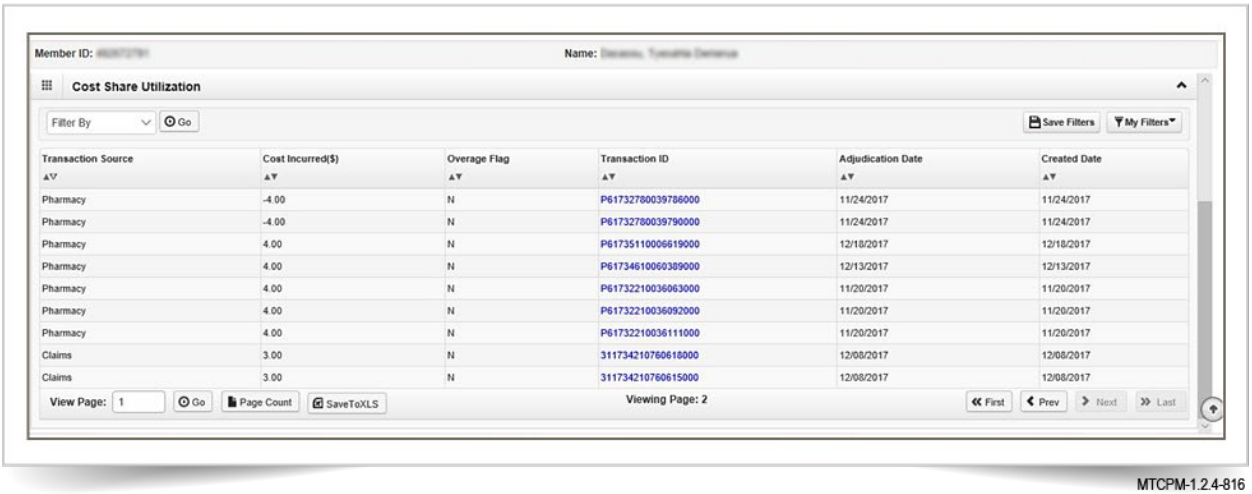


Figure 3.10.11-27. Cost Share Utilization Screen.

PP18

The Contractor's solution shall calculate each claim's cost share (e.g., copayments, LTC patient liability) as specified by the Agency.

The evoBrix X Core Claims module features pre-defined rules to calculate cost share for co-payments and LTC patient liability based on DPHHS-specific business rules as shown in Figure 3.10.11-28 and Figure 3.10.11-29. Our solution also applies cost sharing to manually priced claims.

Our solution maintains cost share details for a beneficiary and a household for each quarter. Our solution calculates a household bucket for cost share in real time and, after applying the existing pricing, it applies a co-pay. If the cost share remaining amount is less than the co-pay, then our solution reduces the co-pay to the remaining amount of the cost share.

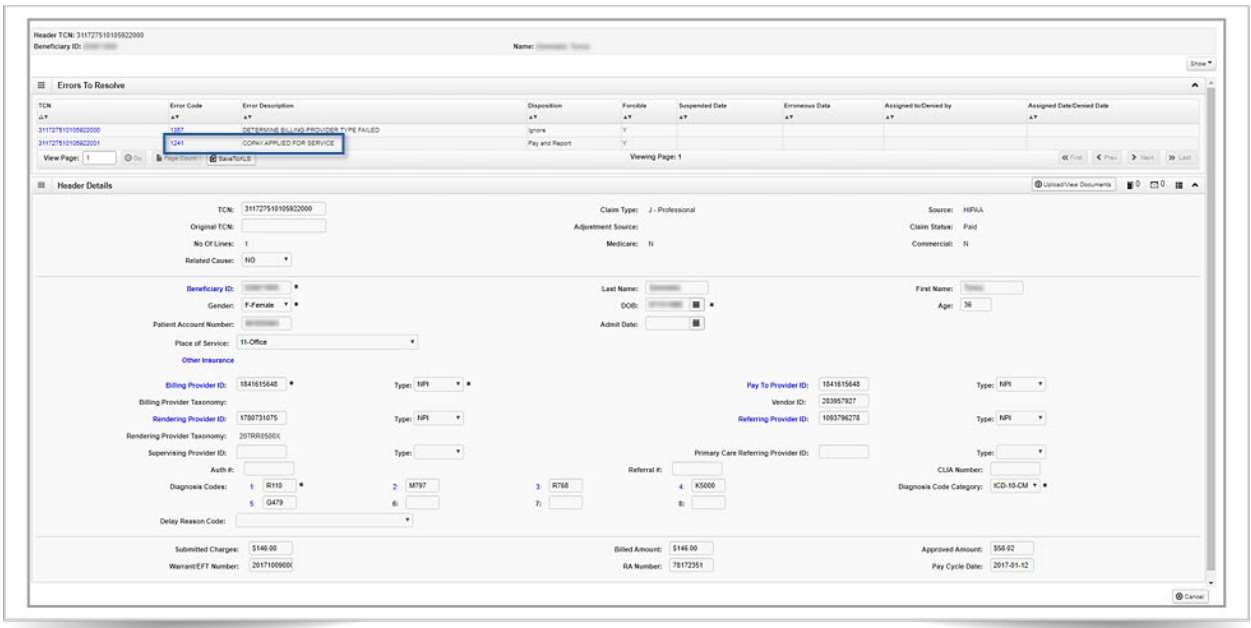


Figure 3.10.11-28. The Header Detail screen with pay and report applied to a co-pay.

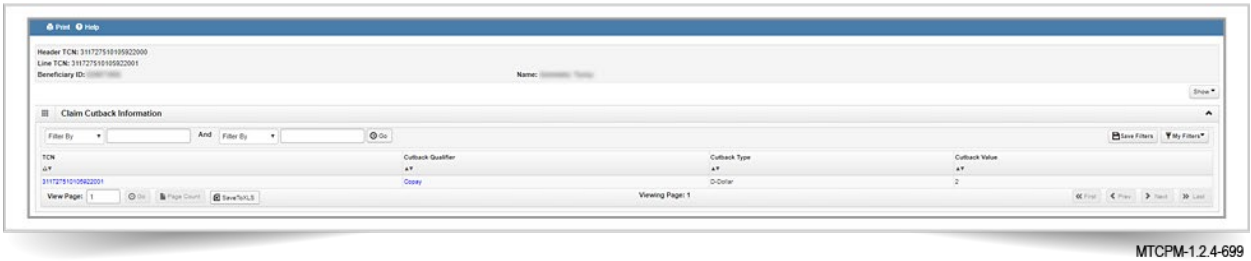
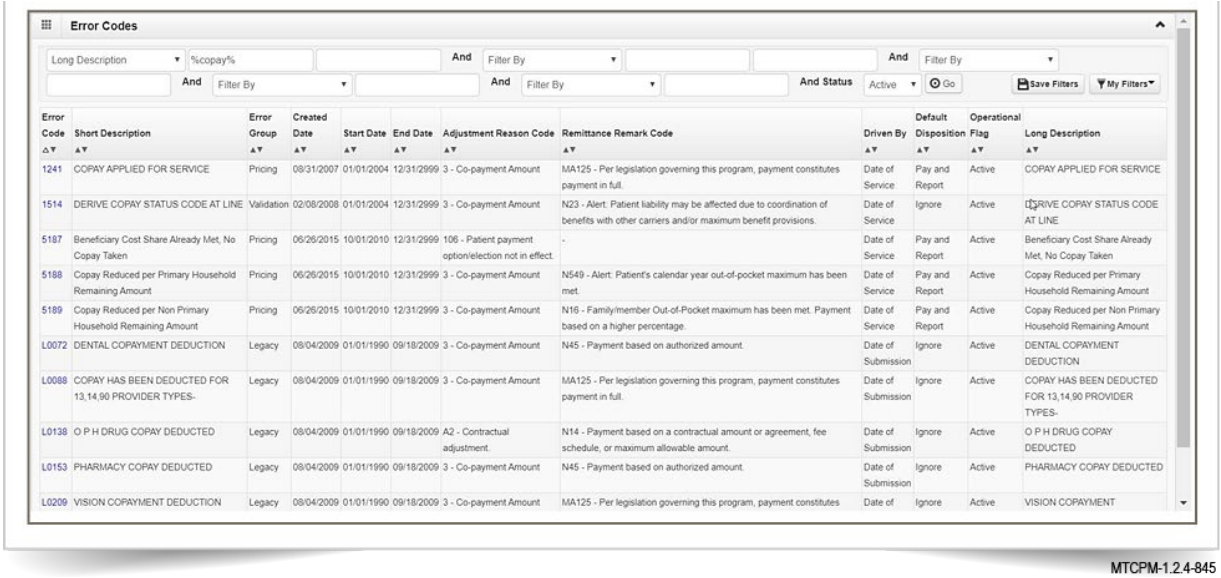


Figure 3.10.11-29. The Cutback screen displays co-pay liability applied on the service line.

Figure 3.10.11-30 displays several edits posted as a result of applying cost share for claims processing.



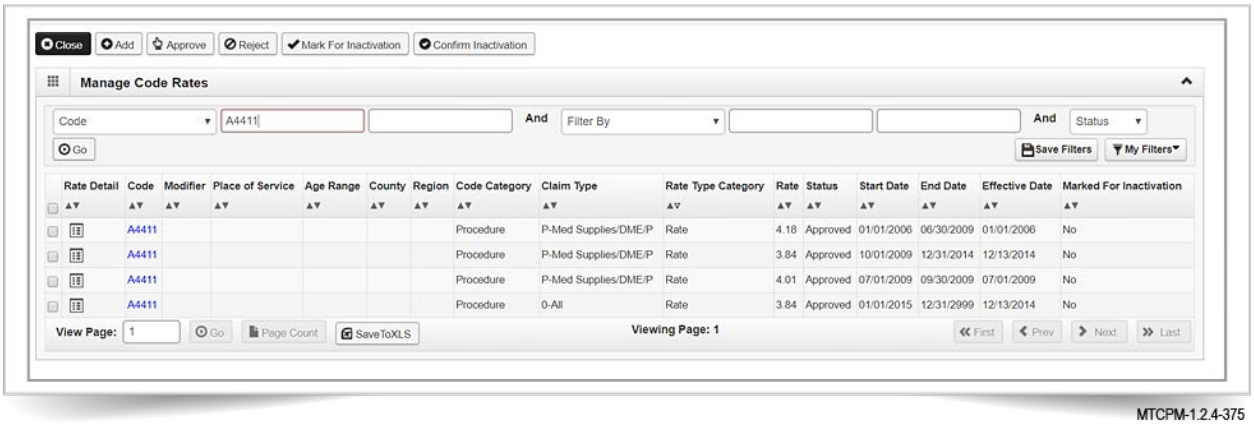
Error Code	Short Description	Error Group	Created Date	Start Date	End Date	Adjustment Reason Code	Remittance Remark Code	Driven By	Default Disposition	Operational Flag	Long Description
1241	COPAY APPLIED FOR SERVICE	Pricing	08/31/2007	01/01/2004	12/31/2999	3 - Co-payment Amount	MA125 - Per legislation governing this program, payment constitutes payment in full.	Date of Service	Pay and Report	Active	COPAY APPLIED FOR SERVICE
1514	DERIVE COPAY STATUS CODE AT LINE	Validation	02/08/2008	01/01/2004	12/31/2999	3 - Co-payment Amount	N23 - Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	Date of Service	Ignore	Active	DERIVE COPAY STATUS CODE AT LINE
5187	Beneficiary Cost Share Already Met, No Copay Taken	Pricing	06/26/2015	10/01/2010	12/31/2999	106 - Patient payment option/election not in effect.	-	Date of Service	Pay and Report	Active	Beneficiary Cost Share Already Met, No Copay Taken
5188	Copay Reduced per Primary Household Remaining Amount	Pricing	06/26/2015	10/01/2010	12/31/2999	3 - Co-payment Amount	N549 - Alert: Patient's calendar year out-of-pocket maximum has been met.	Date of Service	Pay and Report	Active	Copay Reduced per Primary Household Remaining Amount
5189	Copay Reduced per Non Primary Household Remaining Amount	Pricing	06/26/2015	10/01/2010	12/31/2999	3 - Co-payment Amount	N16 - Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	Date of Service	Pay and Report	Active	Copay Reduced per Non Primary Household Remaining Amount
L0072	DENTAL COPAYMENT DEDUCTION	Legacy	08/04/2009	01/01/1990	09/18/2009	3 - Co-payment Amount	N45 - Payment based on authorized amount.	Date of Submission	Ignore	Active	DENTAL COPAYMENT DEDUCTION
L0088	COPAY HAS BEEN DEDUCTED FOR 13,14,90 PROVIDER TYPES-	Legacy	08/04/2009	01/01/1990	09/18/2009	3 - Co-payment Amount	MA125 - Per legislation governing this program, payment constitutes payment in full.	Date of Submission	Ignore	Active	COPAY HAS BEEN DEDUCTED FOR 13,14,90 PROVIDER TYPES-
L0138	O P H DRUG COPAY DEDUCTED	Legacy	08/04/2009	01/01/1990	09/18/2009	A2 - Contractual adjustment.	N14 - Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	Date of Submission	Ignore	Active	O P H DRUG COPAY DEDUCTED
L0153	PHARMACY COPAY DEDUCTED	Legacy	08/04/2009	01/01/1990	09/18/2009	3 - Co-payment Amount	N45 - Payment based on authorized amount.	Date of Submission	Ignore	Active	PHARMACY COPAY DEDUCTED
L0209	VISION COPAYMENT DEDUCTION	Legacy	08/04/2009	01/01/1990	09/18/2009	3 - Co-payment Amount	MA125 - Per legislation governing this program, payment constitutes	Date of	Ignore	Active	VISION COPAYMENT

Figure 3.10.11-30. This screen shows cost share applied during claims processing.

PP19

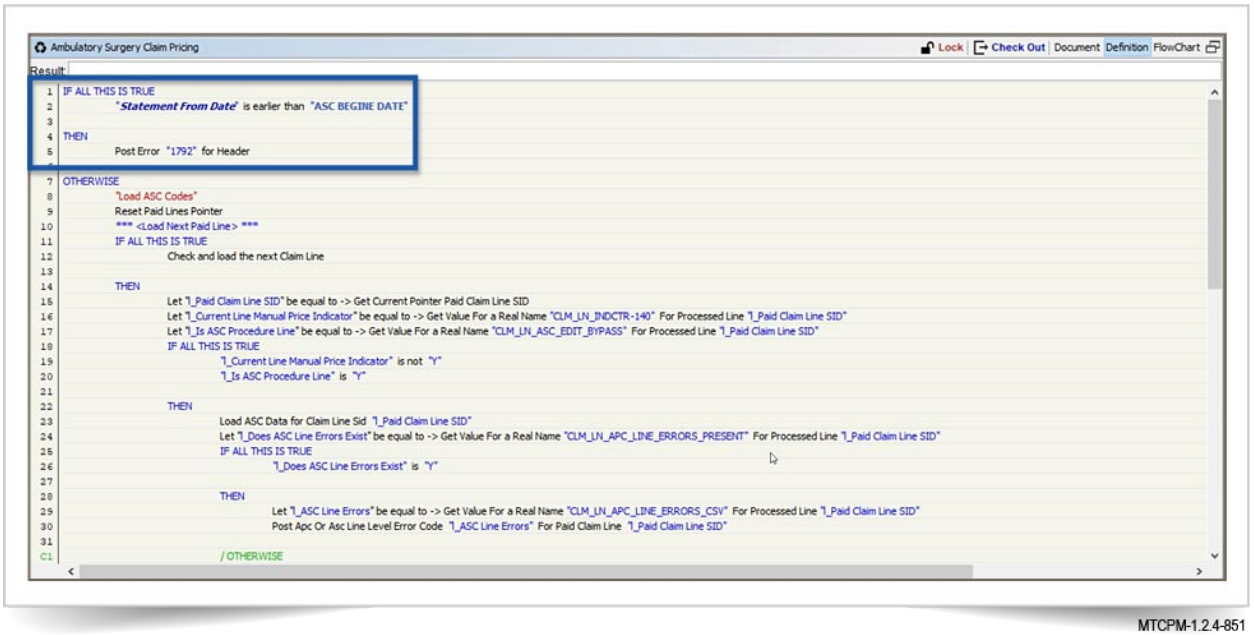
The Contractor's solution shall price claims according to pricing data and reimbursement methodologies applicable on the date(s) of service on the claim.

The evoBrix X Core Claims module includes layered pricing rules in the RuleIT platform, which are based on the invoice type, claim type, and the reimbursement methodology that Team CNSI must apply during claims pricing. We apply time-sensitive claims adjudication rules according to the date of service on a claim. The RuleIT platform also includes the flexibility to invoke rule-based date(s) of service by applying the reference data set up when pricing a claim. See Figure 3.10.11-31 and Figure 3.10.11-32 for more information.



MTCPM-1.2.4-375

Figure 3.10.11-31. The History Rate screen displays different rates based on effective dates.



MTCPM-1.2.4-851

Figure 3.10.11-32. This screen displays a date-sensitive description of the pricing rules.

PP20

The Contractor's solution shall include configurable alerts to notify the appropriate work unit of any payment changes requiring further review or investigation (e.g. statistical variances or rapid payment changes). The Agency shall define the work unit and notification process.

Team CNSI's evoBrix X CPMS solution includes configurable HealthBeat metrics to alert users on statistical variances and rapid status changes of payments that many require review or investigation. However, we will need to customize our solution to develop new alerts and notifications specific to the MT CPMS project. These metrics are driven based on DPHHS business rules related to the work unit and notification process. We can configure our solution with statistical variances and/or rapid payment change alerts and notifications for the metrics with applicable thresholds. Upon breaching a threshold, our solution sends a notification to appropriate users as shown in Figure 3.10.11-33.

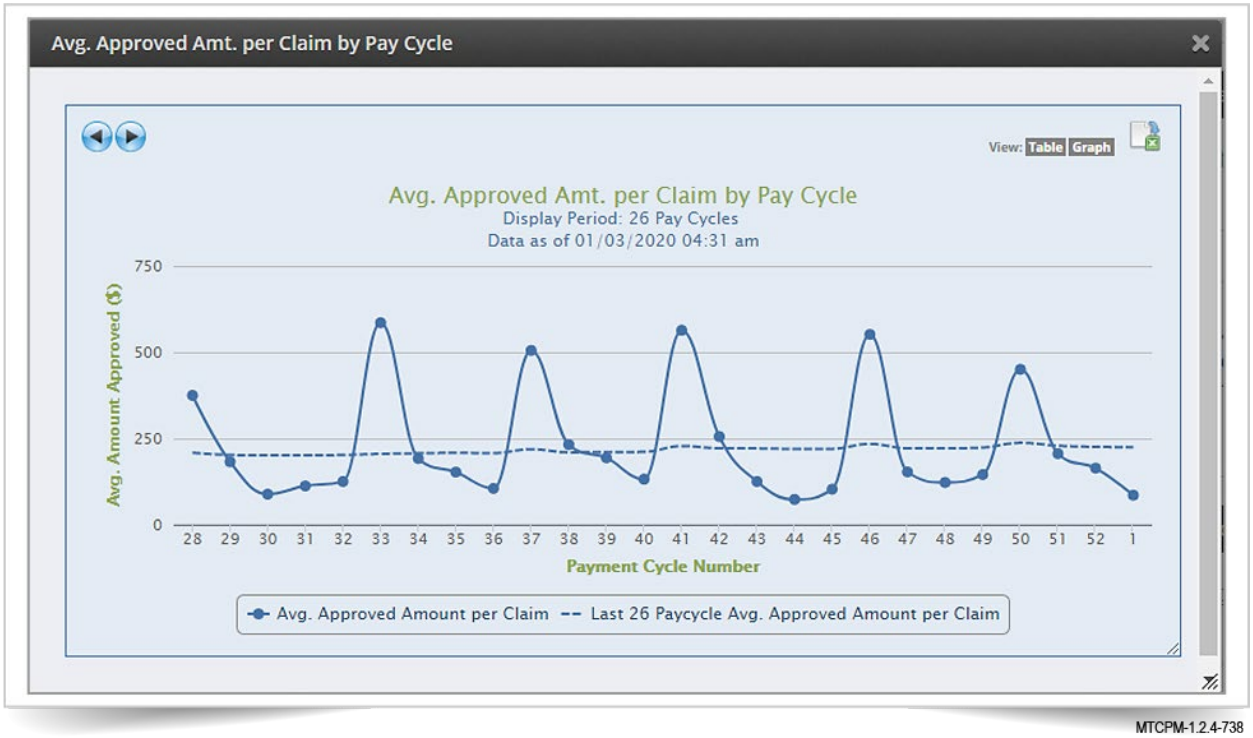


Figure 3.10.11-33. This screen displays a configurable notification in HealthBeat per the claim by pay cycle.

PP21

The Contractor's solution shall reimburse providers' inpatient claims identified as client transfers based on the Agency's pricing methodology.

The evoBrix X Core Claims module includes functionality to reimburse providers' inpatient claims that have been identified as client transfers according to the DPHHS pricing methodology as shown in Figure 3.10.11-34. Based on the client transfer notification, our solution prices Long Term Care (LTC) inpatient claims according to applicable provider per-diem rates. The evoBrix X Core Claims module edits claims to ensure appropriate provider notifications, placing the ownership on the provider to maintain accurate claims processing procedures.

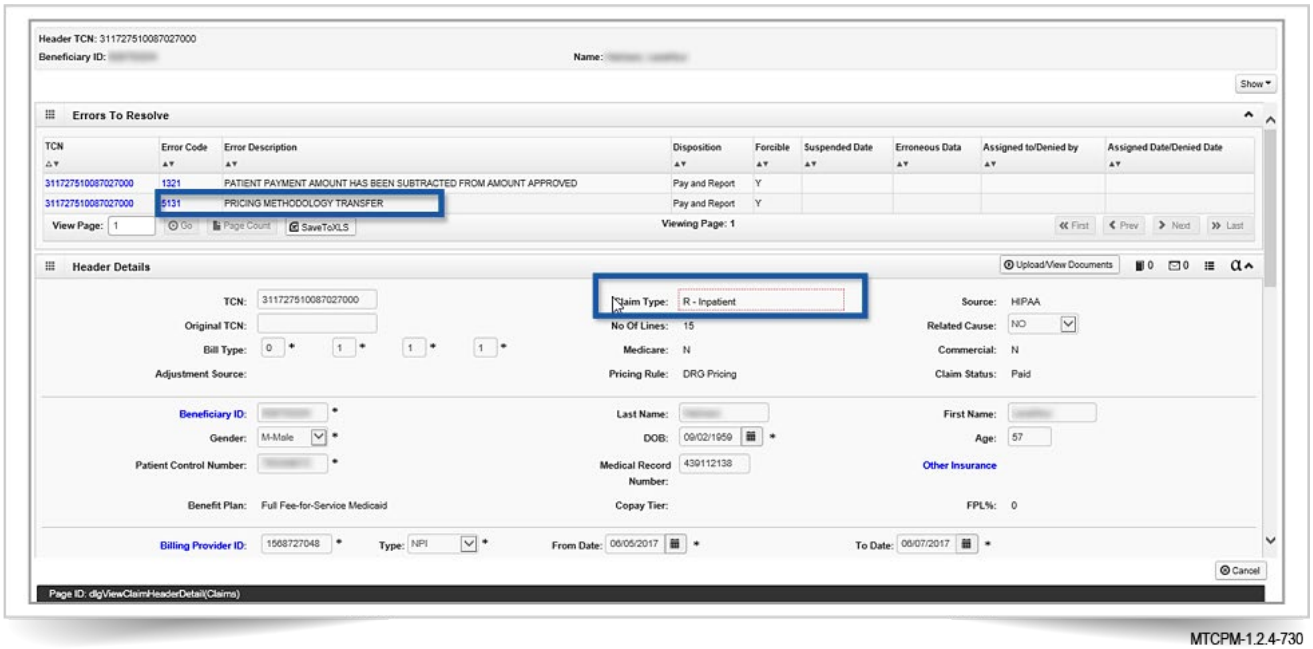


Figure 3.10.11-34. Inpatient claims provider reimbursement for client transfers and setting 5131 transfer editing.

PP22

The Contractor's solution shall reimburse providers short stay inpatient claims based on the Agency's pricing methodology.

The evoBrix X Core Claims module applies different payment methodologies to reimburse short-stay inpatient claims according to the DPHHS pricing methodology. As shown in Figure 3.10.11-35, our solution leverages the APR-DRG 3M Grouper for inpatient pricing. We configure our solution to price claims with the per diem rate or the fixed rate as specified in a provider's contract.

When a claim is billed with less than the average length of stay for the DRG code, Team CNSI applies the short-stay pricing rate as defined in the DRG rate factors. The RuleIT platform then applies the respective inpatient short-stay rates for the date of service, as required.

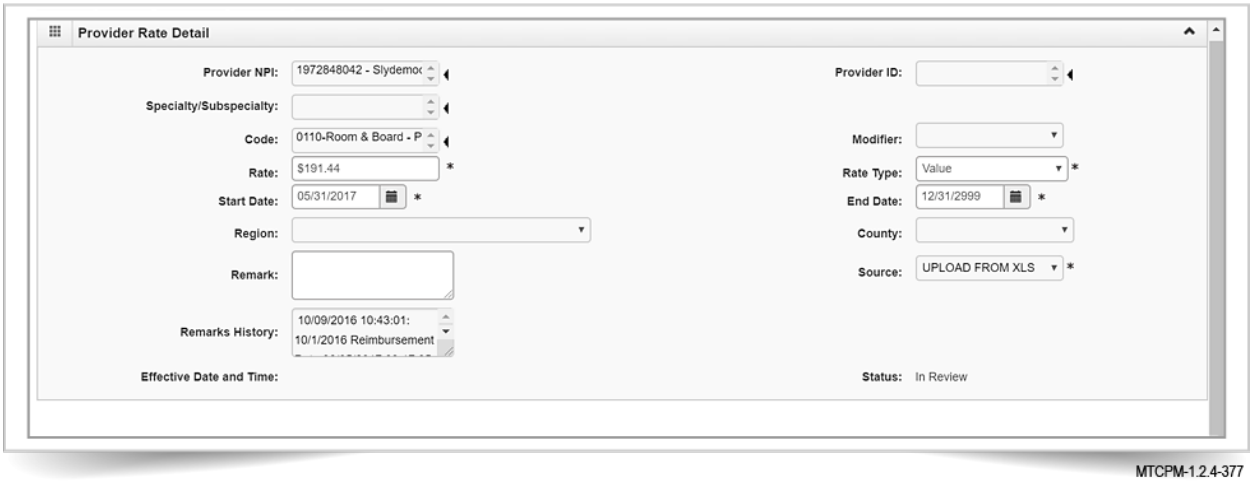
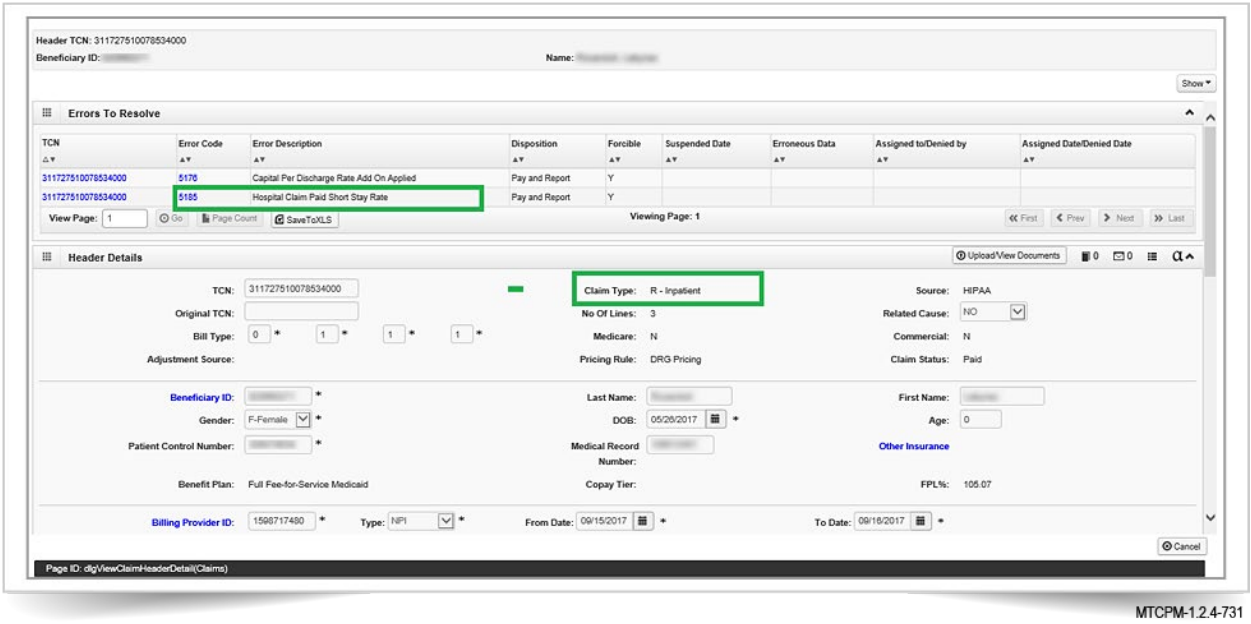


Figure 3.10.11-35. This screen displays price claims with the short stay rates per diem.

Figure 3.10.11-36 shows where a claim is priced using a short stay reimbursement with 5185 editing at the claim header level.



MTCPM-1.2.4-731

Figure 3.10.11-36. This screen displays a hospital claim paid through short stay pricing.

PP23

The Contractor's solution shall reimburse providers pro-rated eligibility inpatient claims (e.g., overlapping benefit plans, changes in benefit plan) based on the Agency's pricing methodology.

The evoBrix X Core Claims module includes pre-defined rules to determine member eligibility on the applicable date of service. As such, we can customize our solution to reimburse pro-rated eligibility inpatient claims per the DPHHS pricing methodology. Member eligibility is determined for the claim header or claim line based on the applied pricing methodology. Our solution includes special rules that consider all member eligibility criteria to determine the appropriate eligibility through co-existing benefit plans and restrictions.

PP24

The Contractor's Solution shall have the ability to support outlier and interim billing as defined by the Agency.

As shown in Figure 3.10.11-37, the evoBrix X Core Claims module supports outlier and interim billing per DPHHS requirements. Our solution processes interim billings as regular claims and reviews them for duplicate claims to avoid payment errors. Inpatient claims are priced through DRG, per-diem, and contract payments. Additional payments (e.g., outliers) are calculated and reimbursed based on the services identified on the claim and the cost-to-charge ratio.

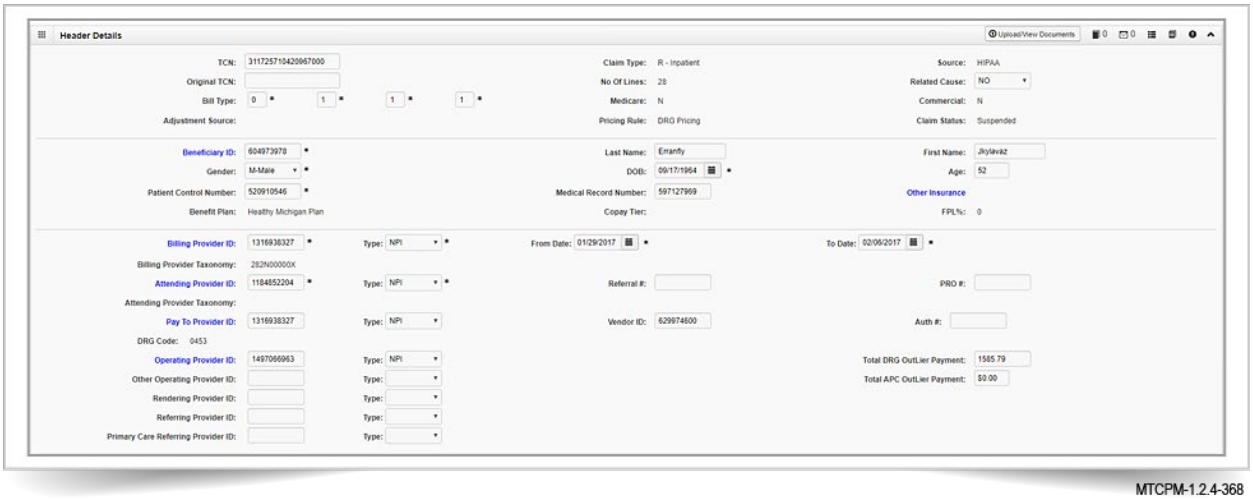


Figure 3.10.11-37. This Header Detail screen shows where outlier payments are captured.

PP25

The Contractor's solution shall provide the capability for the Agency to utilize multiple criteria to price services at different rates (e.g., geographic region, benefit plan).

The evoBrix X Core Claims module includes a Rate Setting module to configure rates based on multiple criteria, including place of service, modifier, provider, code, specialty and subspecialty, geographic region, and county (as shown in Figure 3.10.11-38). Our solution also includes pre-defined rules for rates determination, using the rate hierarchy and other factors to identify appropriate rates.

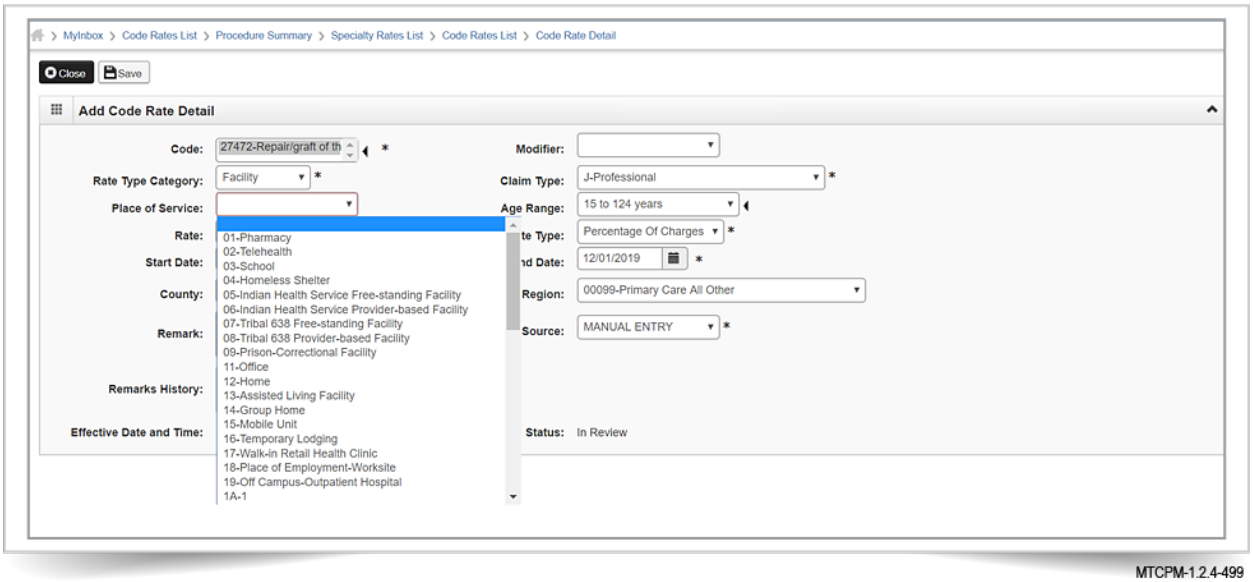


Figure 3.10.11-38. The Rate Detail screen displays multiple criteria (place of service, age, claim type, geographic region) to set rates.

PP26

The Contractor's solution provide the capability to exempt select services or members from cost share based on Federal or State law (e.g., emergency services, preventive services, family planning services, pregnancy related services, generic drugs, immunizations, EPSDT) as defined by the Agency.

The evoBrix X Core Claims module includes configurable restrictions by service types and additional parameters (e.g., race, benefit plan) to exempt select services or members from cost share based on Federal or State law according to DPHHS requirements. Claims adjudication rules include a cost share restriction to determine the cost share amount on a claim. See Figure 3.10.11-39 through Figure 3.10.11-41for more information.

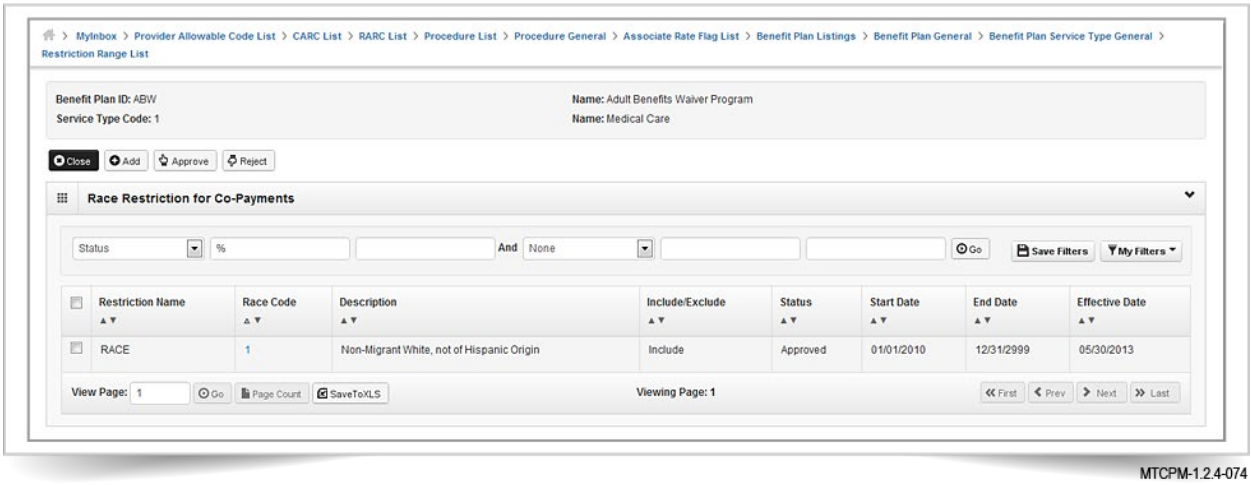


Figure 3.10.11-39. Race Restriction for Co-Payments. The Race Exempt Co-pay screen displays race restriction for co-pays.

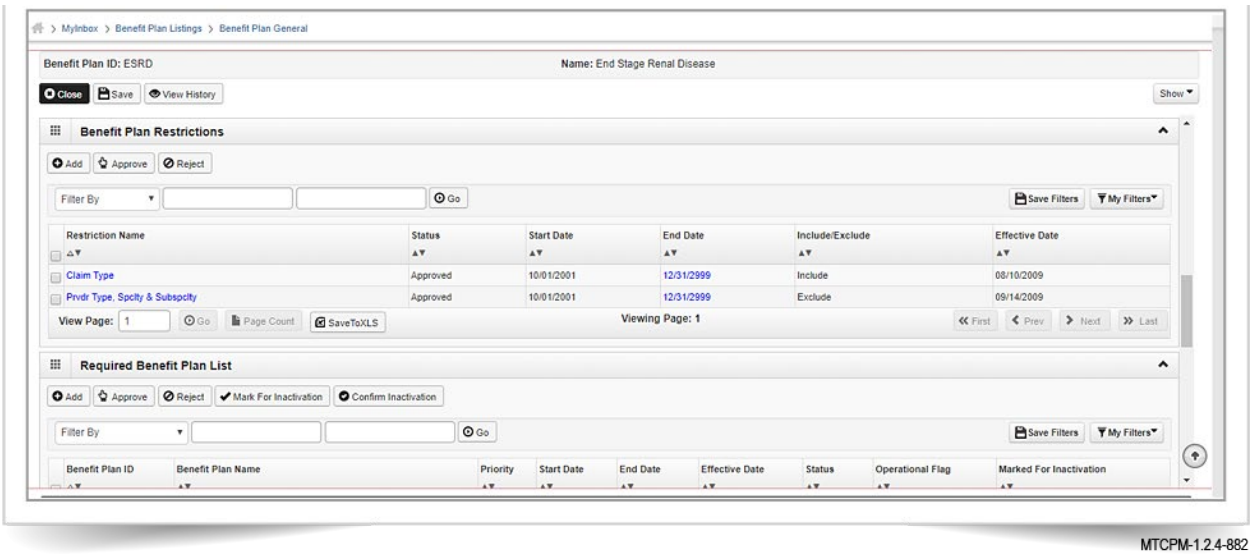


Figure 3.10.11-40. Benefit Plan Restrictions. This screen displays benefit plan restrictions to exempt select services.

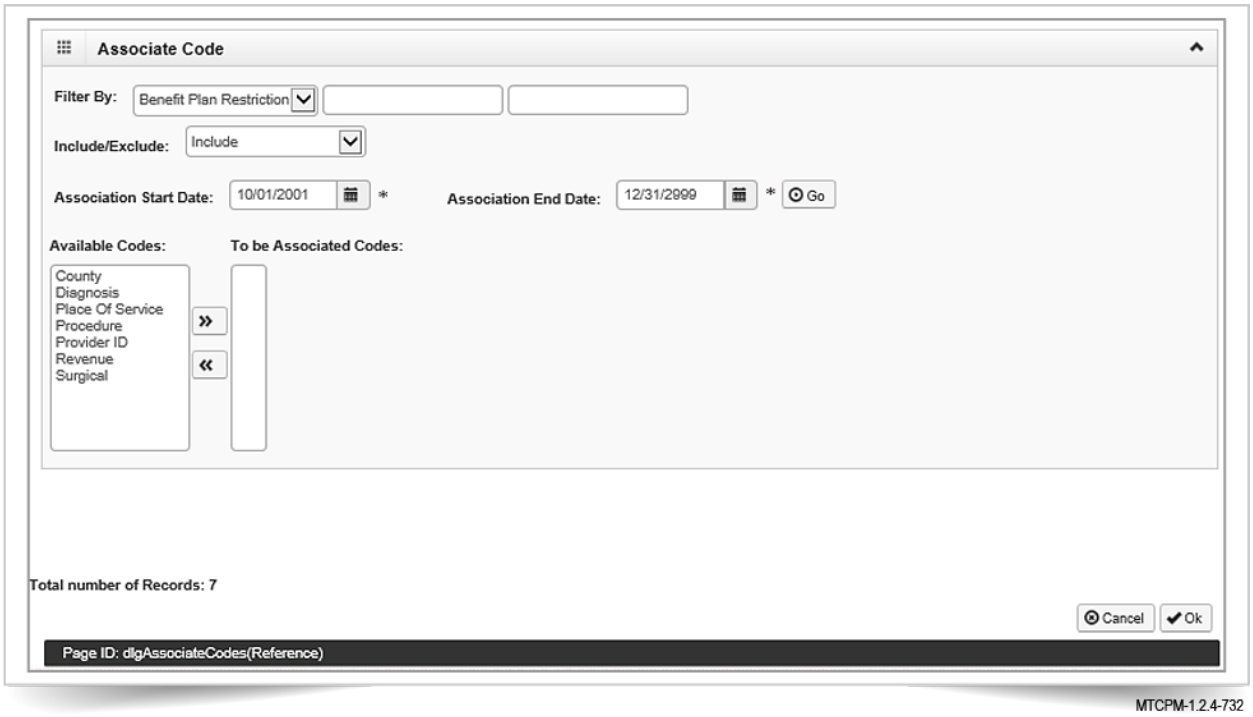


Figure 3.10.11-41. Member Benefit Exclusions. The evoBrix X solution can configure member benefit exclusions and limitations of select services or members from cost share using benefit plan restriction functionality.

PP27

The Contractor's solution shall provide the ability to create and modify rate types (e.g., rate increases/decreases, payment methodologies, beginning and end dates, date of service) based Agency defined business rules. All changes shall be effective dated and provide the user the capability to perform the changes in real time.

Team CNSI designed the evoBrix X Core Claims module with Reference and Rate Setting components, which we use to configure fee schedules/rate types based on DPHHS rate requirements. We can revise these configurations to adjust pricing in real-time based on rate revisions with effective dates. Pricing rules in the RuleIT platform are date driven and apply date of service to determine applicable rates based on the effective date. See Figure 3.10.11-42 for more information.



Figure 3.10.11-42. The Configurable Rate screen is where users capture and modify rates.

PP28

The Contractor's solution shall provide capability to price medical claims that include physician administered drugs, including compound drugs, as defined by the Agency.

Team CNSI designed the evoBrix X Core Claims module to process and price professional medical claims billed with drug procedure codes (J-Codes) per DPHHS requirements. These claims include physician-administrated drugs, including compound drugs. Physician-administered drugs are priced according to applicable fee schedules and rebates are applied as defined by DPHHS. See Figure 3.10.11-43 and Figure 3.10.11-44 for more information.

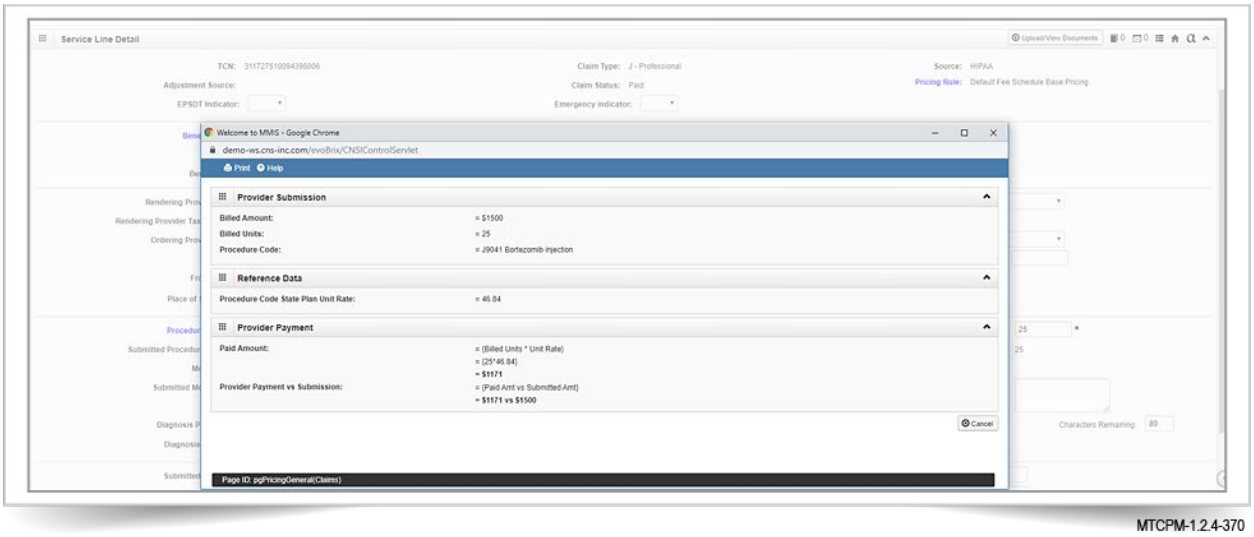


Figure 3.10.11-43. The Drug Pricing screen depicts the calculation of the allowed drug amount.

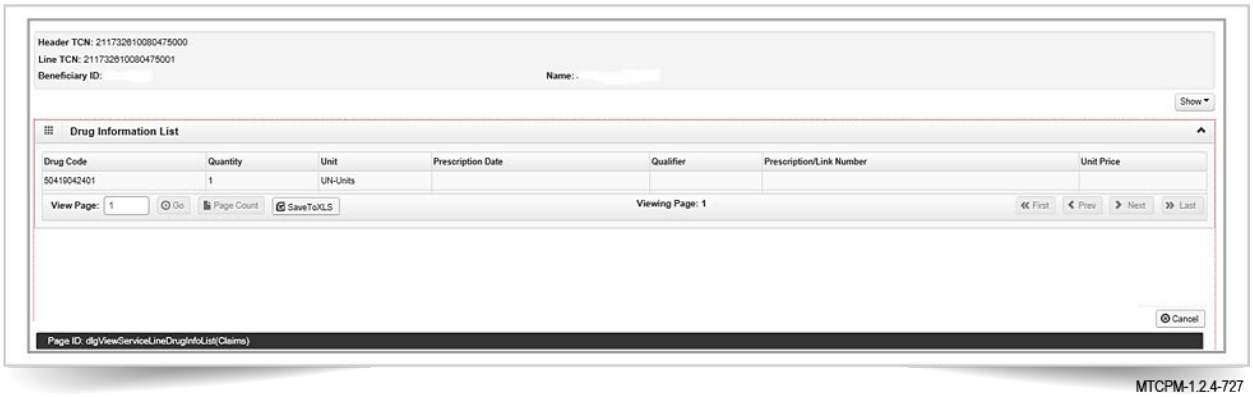


Figure 3.10.11-44. Our solution can accept and price medical claims that include physician-administered drugs.

PP29

The Contractor's solution shall have the ability to apply a rate cap to claim line items based on the prior authorized rate, as defined by the Agency.

The evoBrix X Core Claims module includes the functionality to apply a rate cap to claim line items based on the prior authorized rate, per DPHHS requirements. Our solution includes pre-configured rules within the RuleIT platform that handle Prior Authorization (PA) services according to DPHHS requirements. Our solution then validates claims with a PA tracking number for approval and utilization.

The rates included in the PA request or applicable fee schedule rate are then based on the approval within the PA. See Figure 3.10.11-45 for more information.

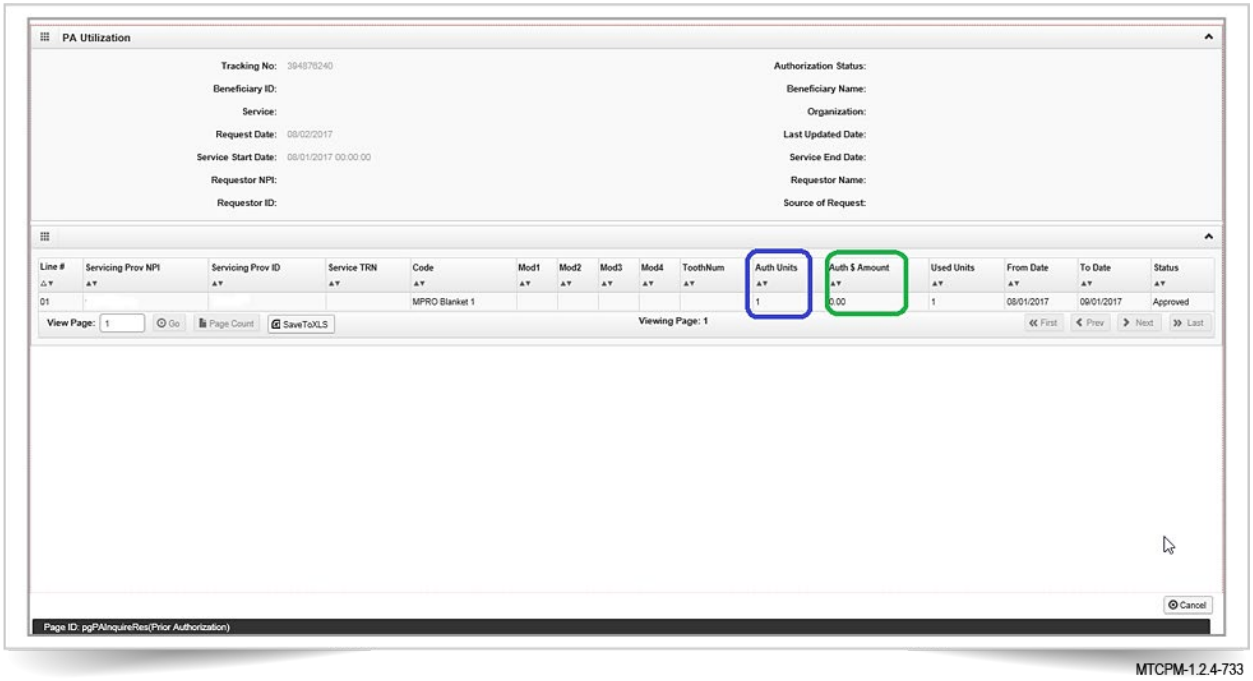


Figure 3.10.11-45. Our solution can apply a rate cap to claim line items based on the prior authorized units or amounts.

PP30

The Contractor's solution shall have the ability to calculate and apply member liability at the header or line level (e.g., FPL, aid category, benefit plan, monthly out of pocket maximum allowance, or other factors) as defined by the Agency.

The evoBrix X Core Claims module includes pre-defined rules within the RuleIT platform to define the various member liabilities that can be calculated or applied at the claim header or claim line level. Our solution applies the configuration in its reference component related to benefit plan restriction, co-pay definition, and restriction for each service type to ensure applicable member liability is deducted in the claim header or claim line. See Figure 3.10.11-46 and Figure 3.10.11-47 for more information.

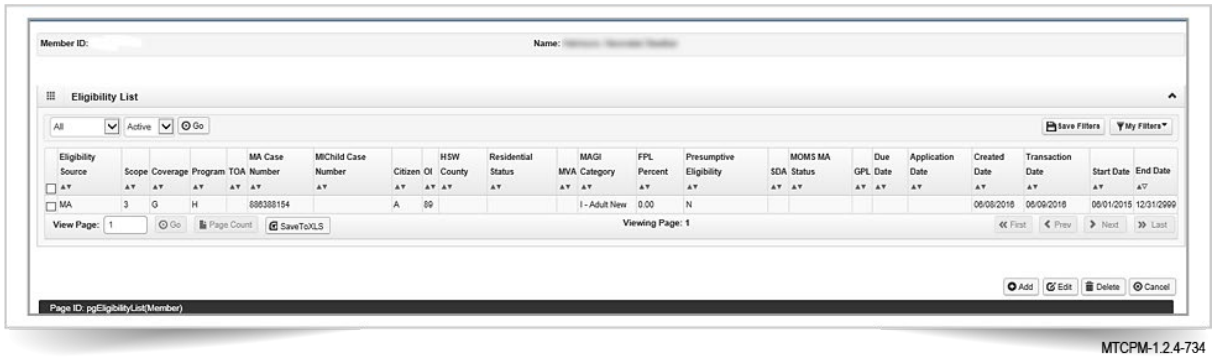


Figure 3.10.11-46. This screen shows member liabilities that can be applied at the claim header or claim line level.

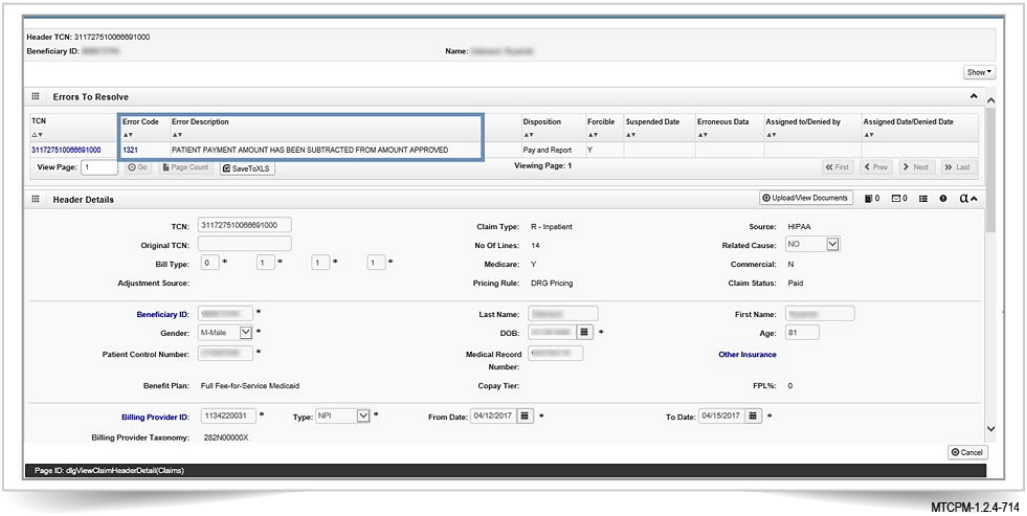


Figure 3.10.11-47. This screen shows where users can calculate monthly out-of-pocket maximum allowance and apply member liability at the claim header level.

PP31

The Contractor's solution shall set a manual pricing indicator flag on a claim that is manually priced by a user. The solution shall capture and store the reason for the manual pricing and identify the user.

The evoBrix X Core Claims module includes an informational edit to flag a claim that has been manually priced. This information is then captured and stored, including the reason for the pricing, in our solution. Team CNSI's evoBrix X Core Claims module can override the approved payment amount by using the manual payment process functionality. The system provides the capability to define the manual pricing indicator on the procedure code in reference module. During adjudication if manual price is derived then adjudication process will override the approved payment amount with manual set amount on the claim. Our solution verifies the billed amount is within reasonable and acceptable limits or if it differs from the allowable fee schedule amount by more than a certain percentage (either above or below), then the claim is flagged and processed for manual review and can override the approved payment amount manually. Authorized users can review the information on screen as shown in Figure 3.10.11-48 and Figure 3.10.11-49.

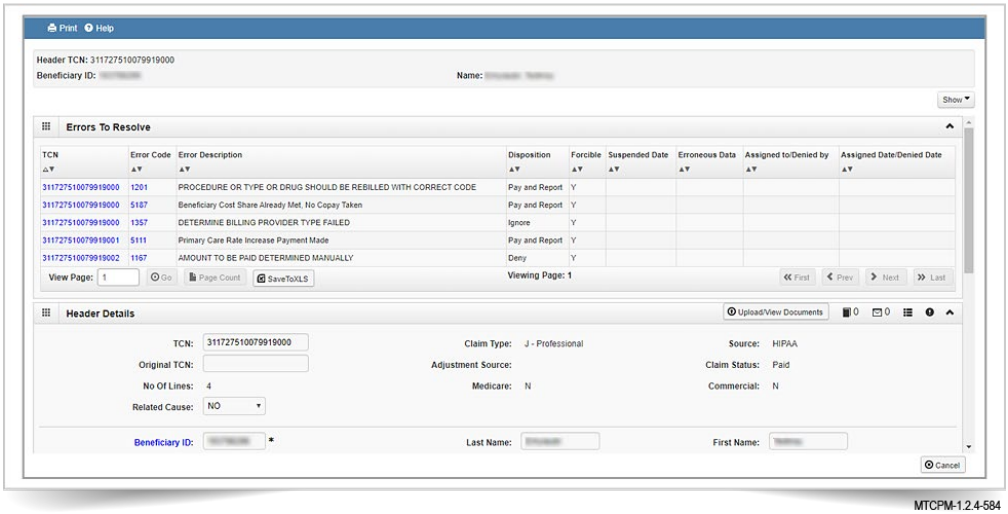
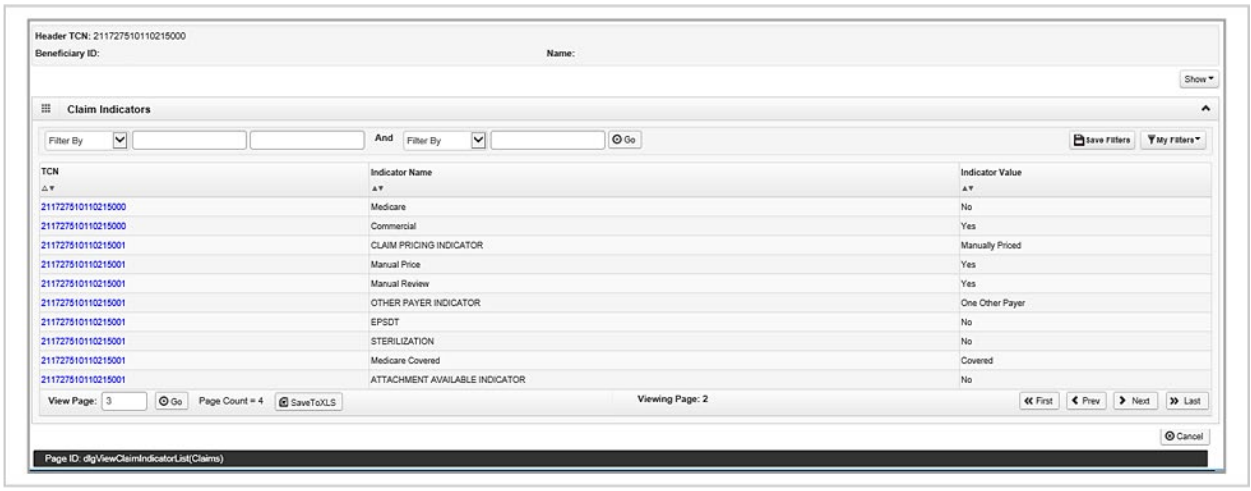


Figure 3.10.11-48. This screen includes an edit display that indicates a manually priced line.



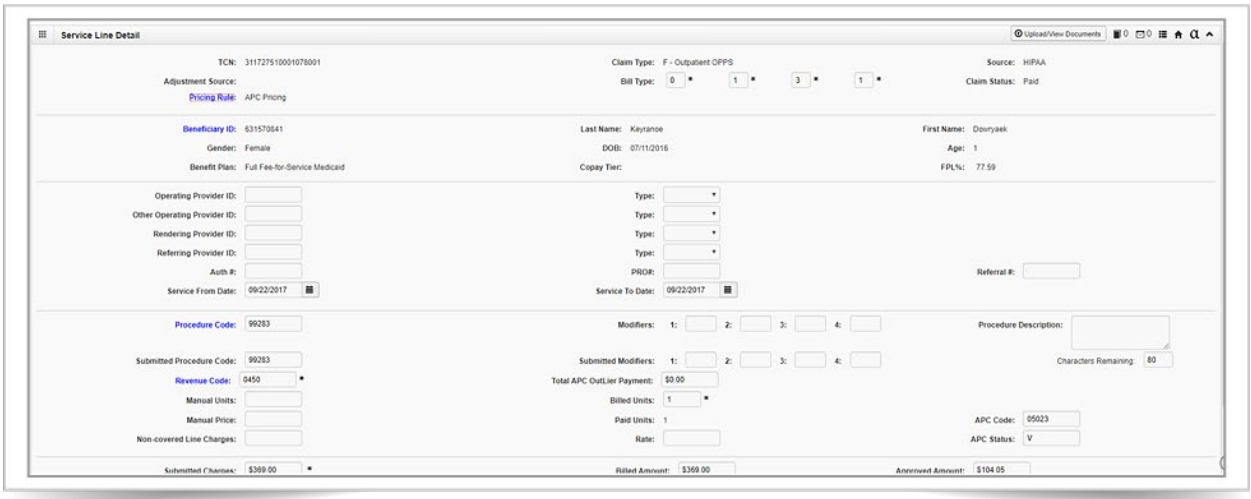
MTCPM-1.2.4-312

Figure 3.10.11-49. Manual Pricing Indicator. Users can override the approved premium payment amount.

PP32

The Contractor's solution shall provide a grouping functionality that supports header and line level grouping methodologies (e.g., APR-DRG, APC) as defined by the Agency.

The evoBrix X Core Claims module processes inpatient claims at the header and/or line level based on APR-DRG pricing. The pre-defined rules leverage integrated real-time 3M APR-DRG and OPPS Grouper services to process claims at the header or line level. Inpatient claims are reimbursed at the header level based on the returned DRG code and priced according to DRG rate factors. Outpatient claims reimbursed at the line level are based on the 3M OPPS using the Ambulatory Payment Classifications (APC) outpatient services grouper (as shown in Figure 3.10.11-50).



MTCPM-1.2.4-371

Figure 3.10.11-50. This screen displays pricing rules for OPPS (APC pricing).

PP33

The Contractor's solution shall utilize configurable data elements and business rules that support the requirements of 42 CFR 447.

Team CNSI pre-configured our evoBrix X CPMS solution to apply claim data elements and pricing methodologies to compute claim reimbursements. We currently process more than 162 million claims per year using the same solution. Our solution provides complete tracking and reporting of claims process and payment information by service category or provider type and our pre-configured pricing methods ensure timely filings, prompt payments, and reimbursements for claims consistent with 42 CFR 447.

PP34

The Contractor's solution shall retain pricing and reimbursement methodologies and their details (e.g., effective and end date, parameters, indicators, gender, age, units, benefit plan) and the audit history of all changes for the determined retention period as defined by the Agency.

The evoBrix X Core Claims module stores various pricing information (e.g., fee schedules, provider-contracted rates, client specific rates, and procedure code rates loaded via back-end processes) and certain details (e.g., fixed rates, percentage of payments, and rates based on age, gender, and benefit plans), which can be configured through online screens, as shown in Figure 3.10.11-51.

We maintain all changes related to parameters, indicators, gender, age, units, benefit plans, etc. in our solution with audit histories that include effective and end dates.

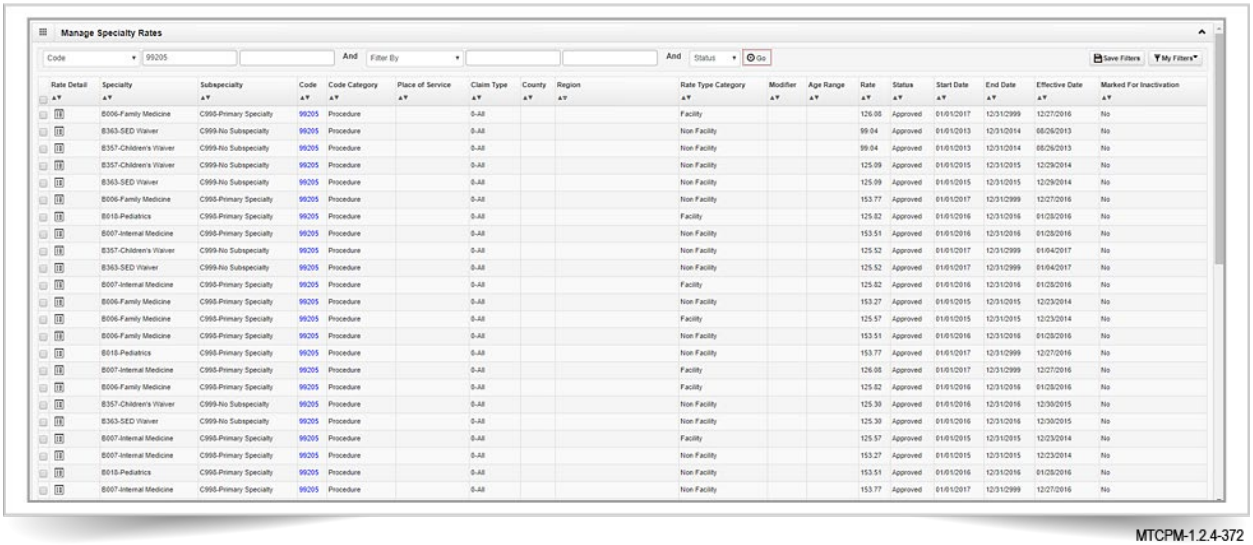


Figure 3.10.11-51. The Facility Rate screen displays rates with audit trails.

PP35

The Contractor's solution shall price all claims according to benefit plans, provider contracts, and methodologies as directed by the Agency.

The evoBrix X Core Claims module prices all claims according to different policies and guidelines within benefit plans, provider contracts, and other methodologies defined by State and Federal rules. We apply the different parameters in code rates, provider rates, specialty rates, and benefit plan rates to ensure we price claims appropriately and accurately.

See Figure 3.10.11-52 and Figure 3.10.11-53 for more information.

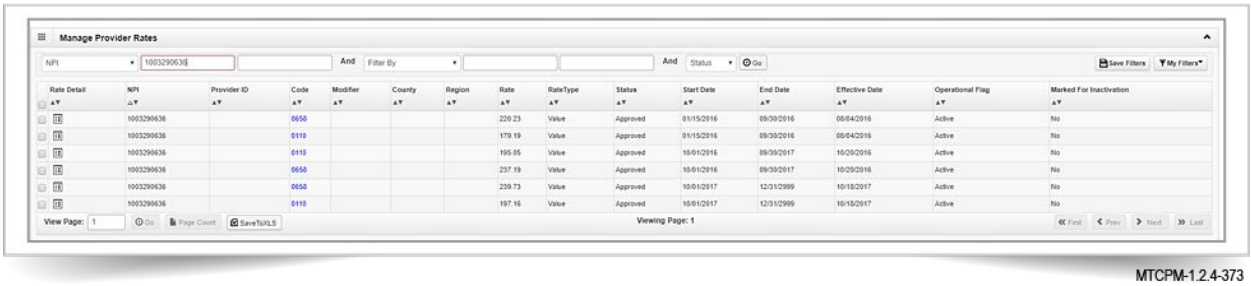


Figure 3.10.11-52. The Provider Rate screen displays different rates based on effective dates.

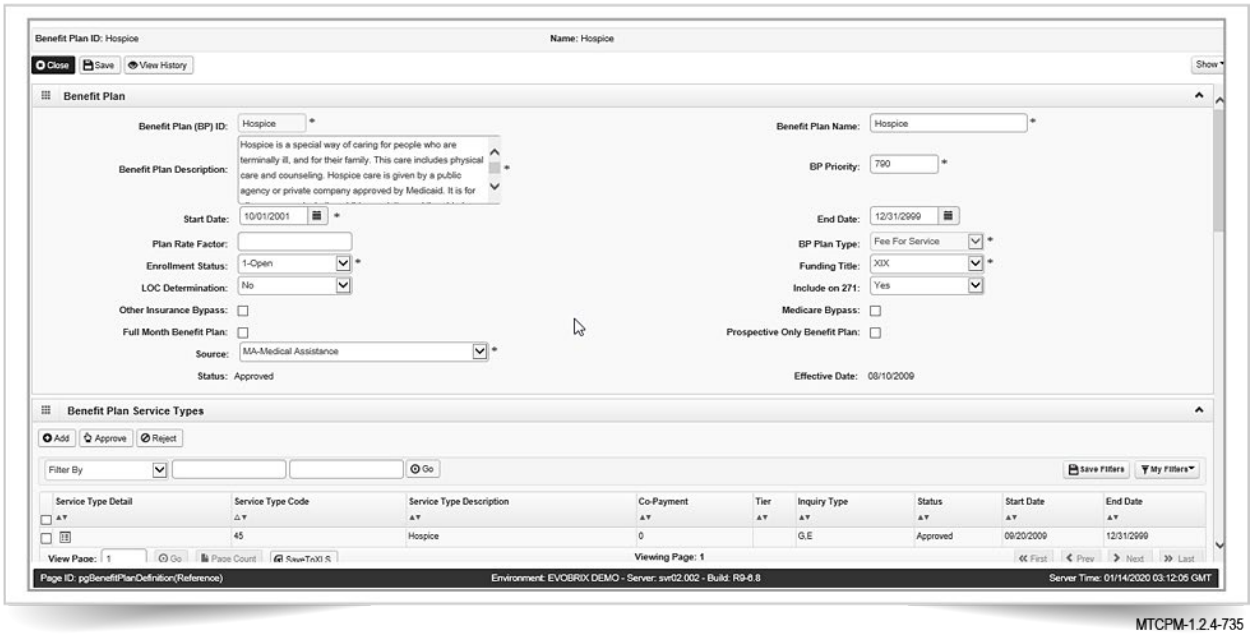


Figure 3.10.11-53. This screen shows how claims are priced according to benefit plans.

PP36

The Contractor's solution shall apply automatic payment adjustments (e.g., incentives and penalties, fixed rates, percentage of approved payments) and apply appropriate incentive pricing as defined by the Agency.

The evoBrix X Core Claims module includes add-on pricing functionality to facilitate the payment of incentives and penalties, fixed rates, and the percentage of approved payments using configurable rules to identify claims that meet applicable payment criteria. The RuleIT platform's rules are defined to evaluate and determine applicable add-on pricing to adjust payment amounts as required and claims payments are reviewed manually and customized to initiate an automatic payment adjustment.

PP37

The Contractor's solution shall provide the ability to configure payment adjustments (e.g., incentives and penalties, fixed rates, percentage, benefit plan) and schedule or automatically execute in real time the adjustment of claims as defined by the Agency.

The evoBrix X Core Claims module includes add-on pricing functionality to facilitate payment adjustments as incentives and penalties, fixed rates, percentage, and benefit plan enhancement amount using configurable rules to identify claims that meet applicable payment criteria. The pre-defined RuleIT platform rules in our solution evaluate and determine applicable add-on pricing to adjust payment amounts as required. Our solution executes these special rules in real-time during claims pricing and stores them with their respective claims as enhancement amounts (as shown in Figure 3.10.11-54).

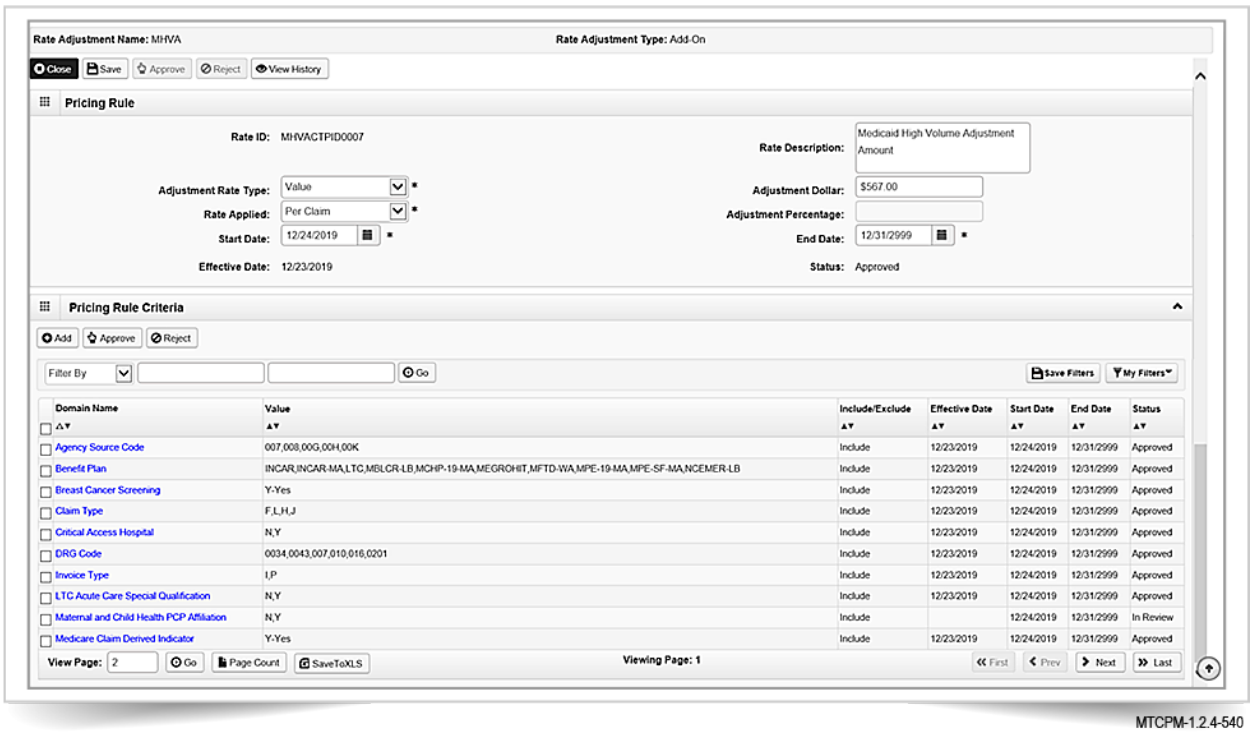


Figure 3.10.11-54. This screen shows configurable add-on pricing rules and domain values.

PP38

The Contractor's solution shall have the ability to price global services (e.g., bariatric surgery, surgical services, surgery, pre- and post-op, prenatal) based on a primary procedure code. Additionally, the solution should allow for pricing incremental services related to the primary procedure code (e.g., lab services, pre- or post-op to the primary service) or services and procedures deemed related and concurrent to the primary procedure code.

The evoBrix X Core Claims module includes standard pricing methodology rules to handle global services. Surgical pricing (e.g., bariatric surgery, surgical services, surgery, pre- and post-op, prenatal) uses a RVU configuration to determine the appropriate rate adjustment to be applied on the base rate of a primary procedure code. Surgical pricing rules determine the primary procedure and other procedures based on National Correct Coding Initiative (NCCI) editing and bundled services.

Our solution captures this information in the RVU Detail screen as shown in Figure 3.10.11-55.

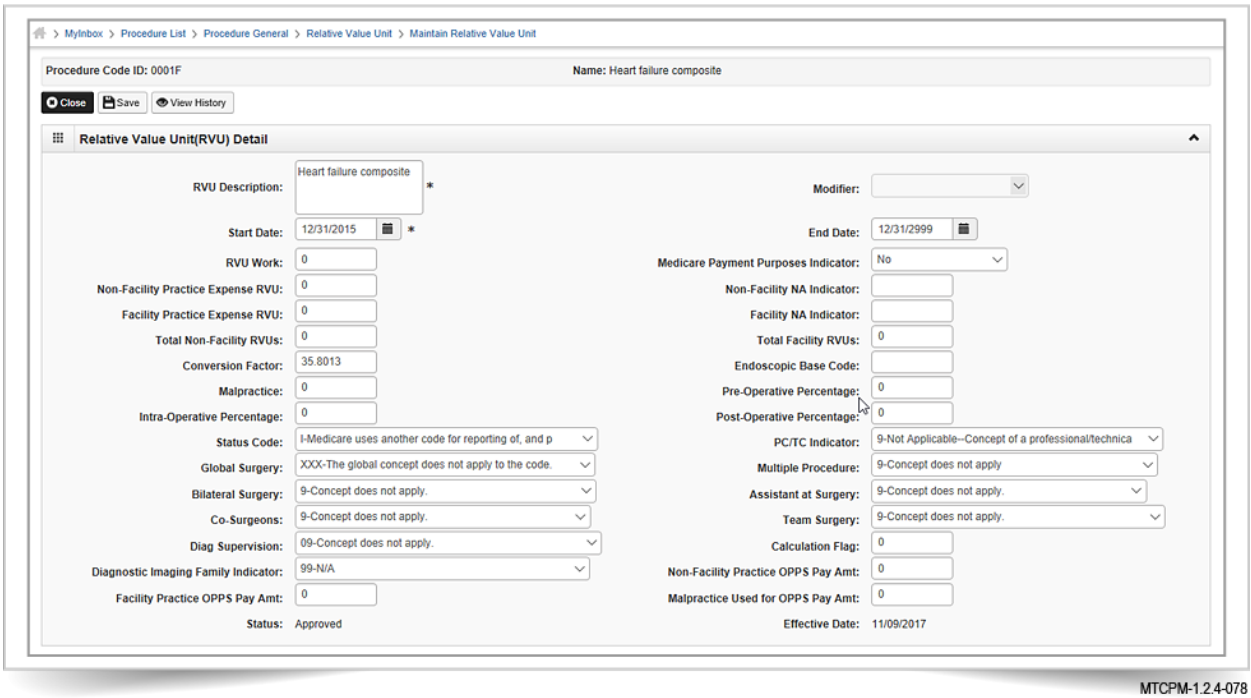


Figure 3.10.11-55. The RVU Detail screen captures information related to policy indicators.

PP39

The Contractor's solution shall apply prior authorization constraints when computing payment amounts using Agency defined criteria.

Team CNSI designed the evoBrix X Core Claims module to store, maintain, and apply PA constraints when computing payment amounts using DPHHS-defined criteria. Claims adjudication is pre-defined to validate services requiring a PA and a tracking number must be submitted on a claim. Based on the PA tracking number, additional rules within our solution validate the PA status and evaluate its utilization to determine payment amount and cutbacks.

If a provider and/or procedure is not authorized for a PA, then our solution denies the claim. Figure 3.10.11-56 highlights this process.

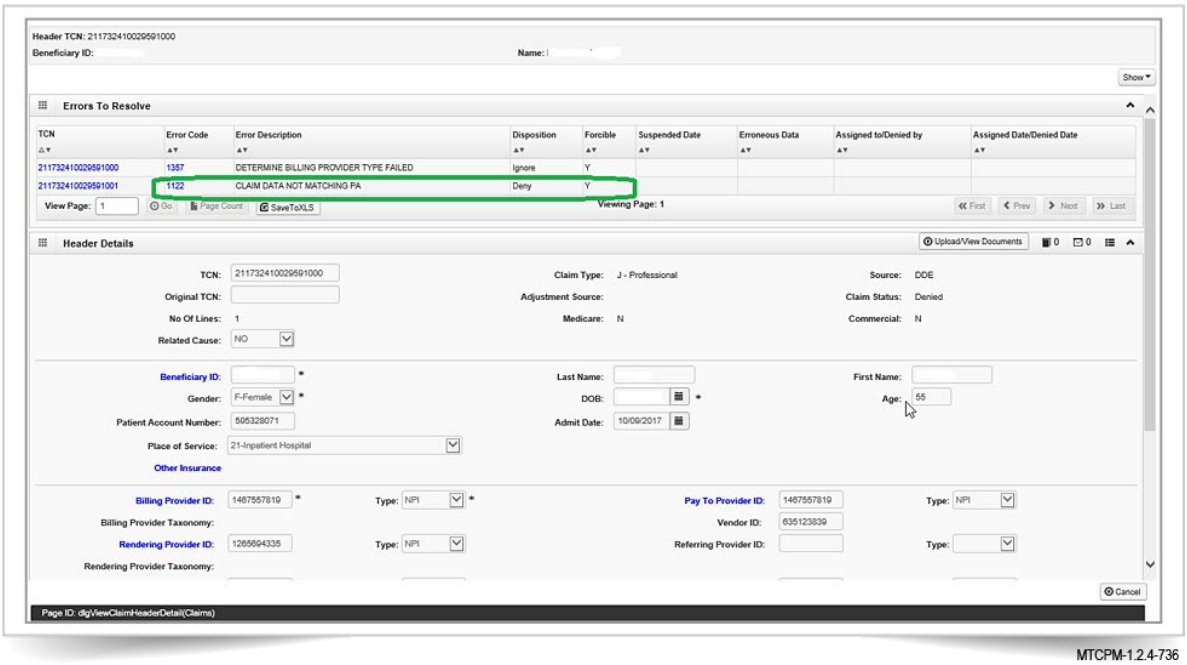


Figure 3.10.11-56. This screen shows PA constraints when computing payment amounts and claim denying when claim data does not PA data.

PP41

The Contractor's solution shall provide the ability to configure, record, and maintain the proportion of the payment (e.g., percentage, fixed amount, claim type, provider type, service) to be reimbursed to each payee as defined by the Agency.

Team CNSI designed the evoBrix X Core Claims module to configure, record, and maintain all derived payment elements as part of our claims adjudication process. These derived elements include member eligibility (benefit plan), provider type, service type, EPSDT, pregnancy services, claim type, cutbacks, and enhancement amount. Our solution processes claims through account coding to ensure that appropriate payment definitions are assigned for each payee (as shown in Figure Figure 3.10.11-57).

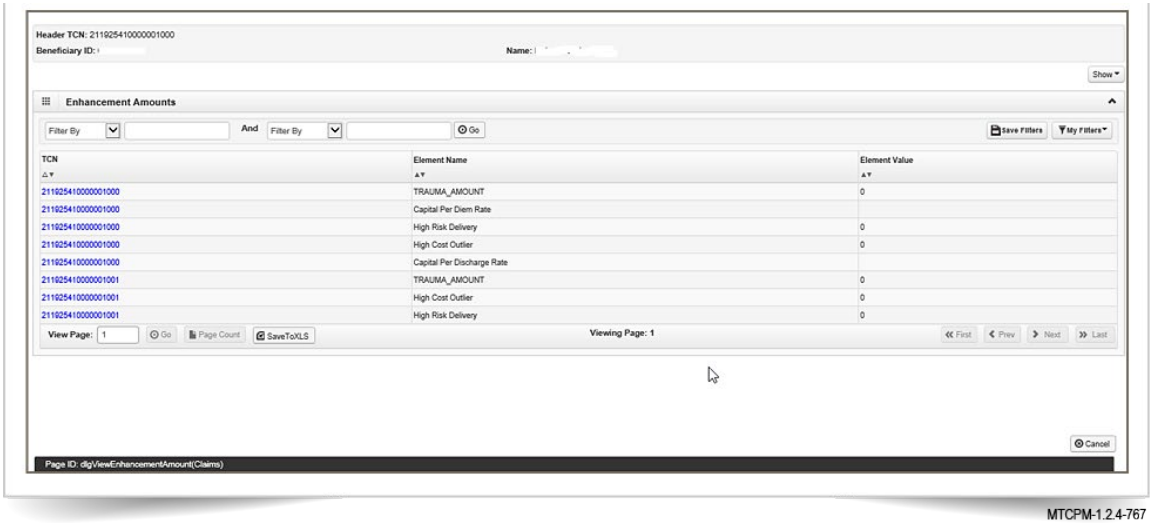


Figure 3.10.11-57. This screen shows where our solution maintains the proportion of the payment in the enhancement amounts.

PP42

The Contractor's solution shall perform claims processing for encounter claims, including editing, pricing, reporting, in a manner consistent with the standard fee for service claims (i.e., shadow pricing). The results shall be stored and no reimbursement to the provider will be generated.

The evoBrix X Core Claims module accepts and processes managed care encounter claims, and the business rules configured in the RuleIT platform determine the appropriate claim type. We apply DPHHS-defined payment methodologies to the encounters, which include, but are not limited to: DRG payments; the fee schedule; fixed rates; and the percentage of payments applicable for each respective claim type.

Encounters are shadow priced like FFS claims and our solution stores and maintains all derived elements related to the adjudication process with the encounters. Our solution does not process the encounters as part of the accounting and payment process, nor does it generate a reimbursement and/or RA to a provider. See Figure 3.10.11-58 for more information.

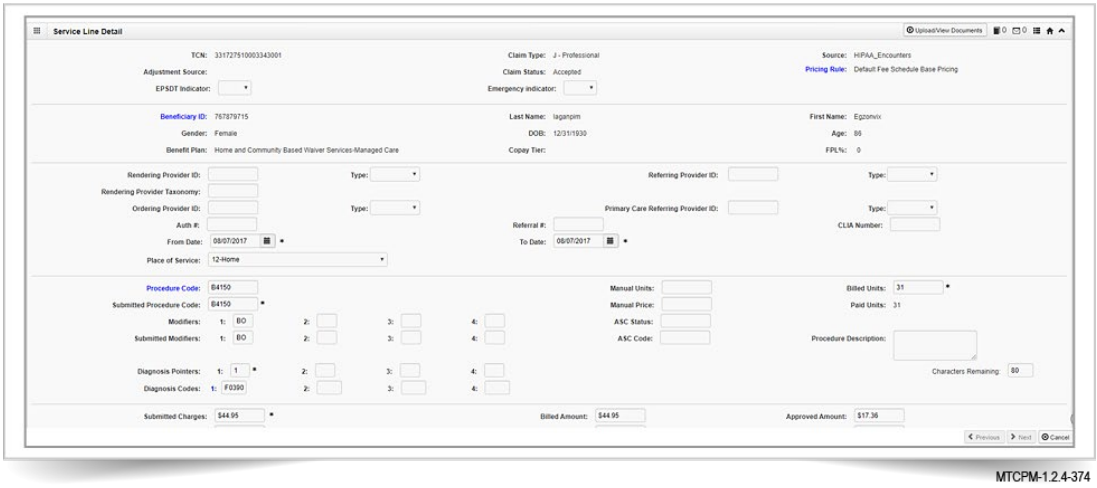


Figure 3.10.11-58. The Header Detail screen where we apply DPHHS-defined payment methodologies to encounters.

PP43

The Contractor's solution shall, upon receipt of TPL information, automatically adjust claims with dates of service within the TPL effective dates.

Team CNSI designed our solution to process TPL information through various lead sources. Based on the TPL eligibility information identified for a member, member claims received during the TPL eligibility effective dates are picked and re-submitted for the TPL payer to process. We review claim payments manually and initiate an automatically adjustment for recoupment based on the payer's Coordination of Benefits (COB).

PP44

The Contractor's solution shall create and maintain an annual maximum payout limit for providers and other Agency-designated entities providing specific services and have the ability to cease payments once the established annual limit has been reached as defined by the Agency.

The evoBrix X core Claim Module includes spending limits for each waiver program and provider enrolled in the MT CPMS project. These providers, as well as other DPHHS-designated entities, must provide specific services, and an accumulator table tracks the paid amount for services rendered by a provider. As such, we will customize our solution to create and maintain an annual maximum payout limit for providers. Once a provider reaches the maximum spending limit, our claims adjudication processes suspend claims that meet the spending limits' identification criteria.

Suspended claims are manually reviewed by authorized claims resolvers prior to their release for payment. Spending limits are re-set on a periodic basis (quarterly or annually) per State and Federal requirements.

PP45

The Contractor's solution shall store the adjudicated encounter claim results (including the managed care plan's paid amount and the shadow-priced fee for service rates) applied to each encounter claim.

The evoBrix X Core Claims module is fully capable of accepting and processing managed care encounter results in the X12 837 format. These encounters undergo a comprehensive series of adjudication steps before being assigned a disposition of "Accepted" or "Rejected."

The evoBrix X Core Claims module processes managed care claims by applying a set of pre-configured business rules within the RuleIT platform, which includes validation processes based on billing standards. The evoBrix X Core Claims module then prices the claims and derives paid amounts for each line or claim level depending on the claim type (as shown in Figure 3.10.11-59). Reports are stored and communicated periodically to appropriate State and federal agencies.

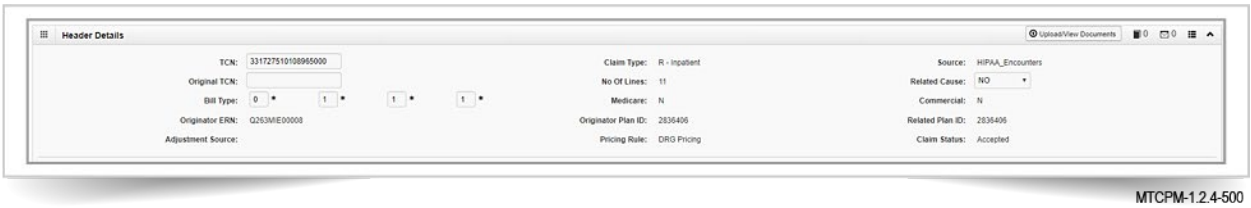


Figure 3.10.11-59. The Header Detail screen displays shadow pricing for encounter claims.

We have successfully implemented our solution in Michigan and Washington as well as other state projects.

PP46

The Contractor's solution shall provide a remittance advice file to the source that includes the adjudication results of each encounter claim and exclude shadow pricing information.

The evoBrix X Core Claims module generates an Encounter Transaction Results Report (ETRR) to notify health plans on the status of submitted encounters. Team CNSI loads, validates, and shadow prices encounters submitted as X12 837 transactions in our solution. Based on the adjudicated results, the encounter is either accepted or rejected. Team CNSI lists the rejected encounters on the ETRR along with the rejection reason code. Figure 3.10.11-60 shows RA details.

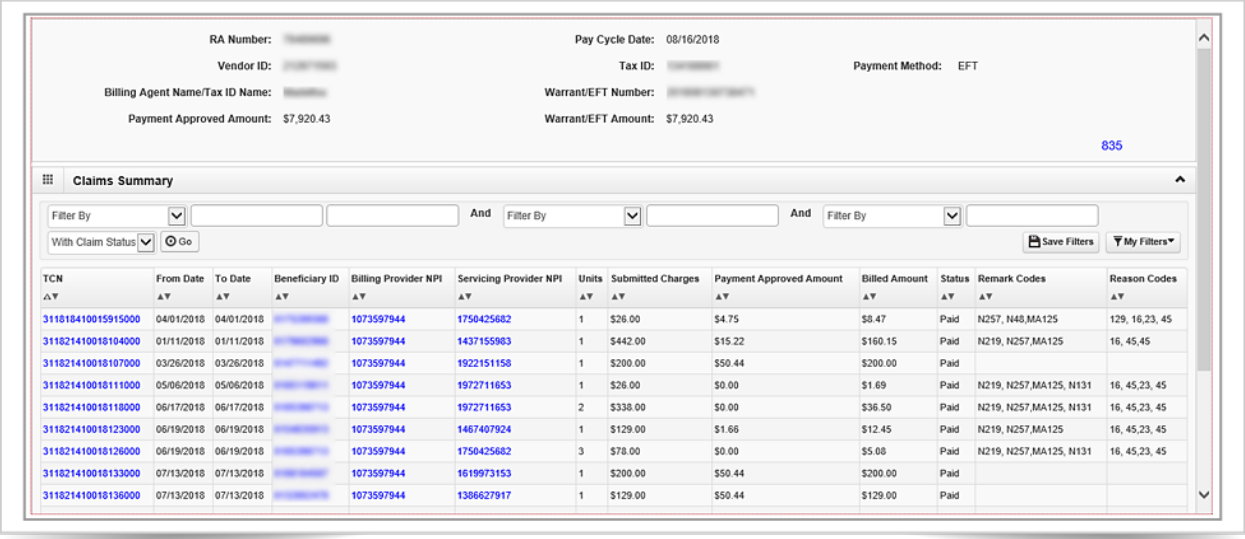


Figure 3.10.11-60. A sample RA that includes adjudication results.

PP47

The Contractor's solution shall receive, store, and update multiple provider per diem rates based on member level of care and/or the provider's qualifications based on configurable business rules.

The evoBrix X Core Claims module receives, stores, and updates multiple provider per diem rates based on a member's level of care and/or a provider's qualifications according to configurable business rules. Our solution includes a rate setting submodule through which authorized users set up rates for procedures as code rates, provider rates, or member rates.

Per-diem rates are typically set up as provider rates as shown in Figure 3.10.11-61, which our solution defines based on the Procedure or Revenue code of the service being performed, as shown in Figure 3.10.11-62. There are additional parameters to revise per-diem rates based on specialty/subspecialty, modifier, county, and region as required to vary the rates. Our solution's pricing rules apply a hierarchy algorithm to determine applicable rates for services rendered and then price claims accordingly.

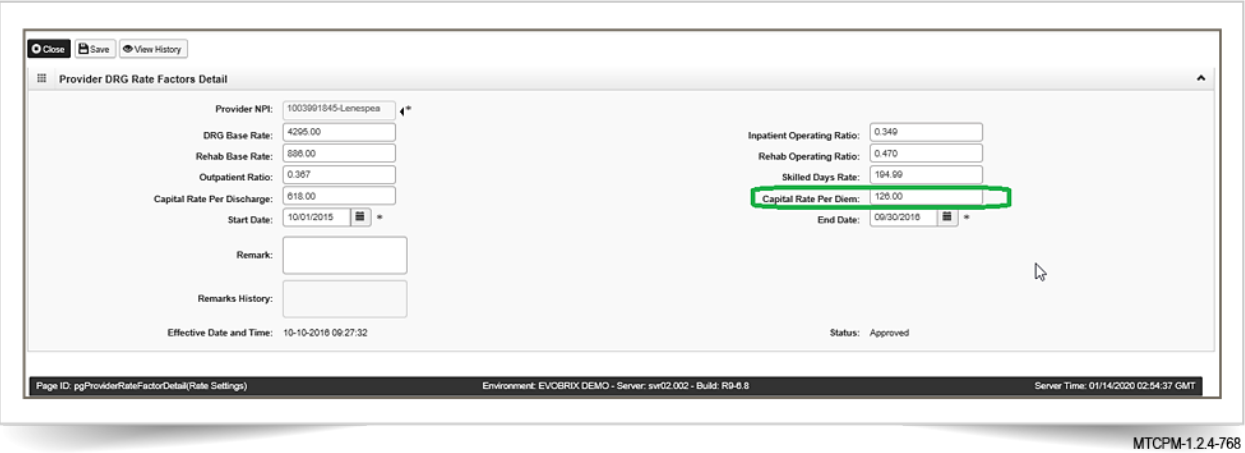


Figure 3.10.11-61. This screen displays provider per diem rates.

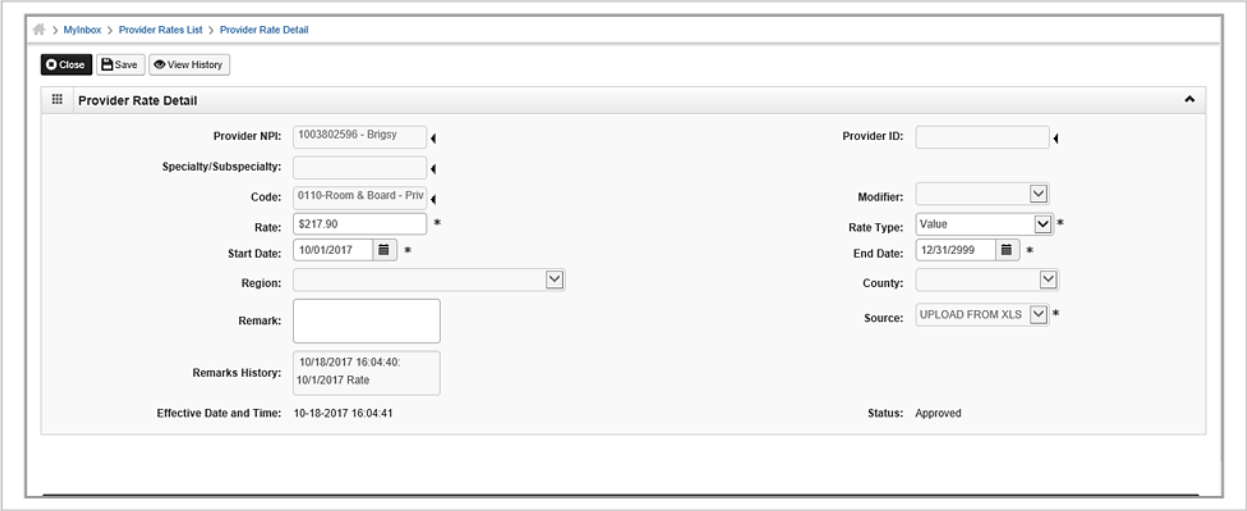


Figure 3.10.11-62. This screen displays additional provider per diem rate information.

PP48

The Contractor's solution shall place claims in suspended status for program or waiver funding limitations, and allow authorized users the ability to release claims for payment upon review.

Users can set up and define spending limits in the Core Claims module as shown in Figure 3.10.11-63. Users can also establish spending limits by provider with a group definition, which they can then use to identify the specific waiver service where they applied the limits.

Our solution flags claims that match pre-determined criteria for use. Based on the utilization limit, our solution's rules engine includes edits to suspend claims for manual review. Individuals then review the claim and determine an appropriate action.

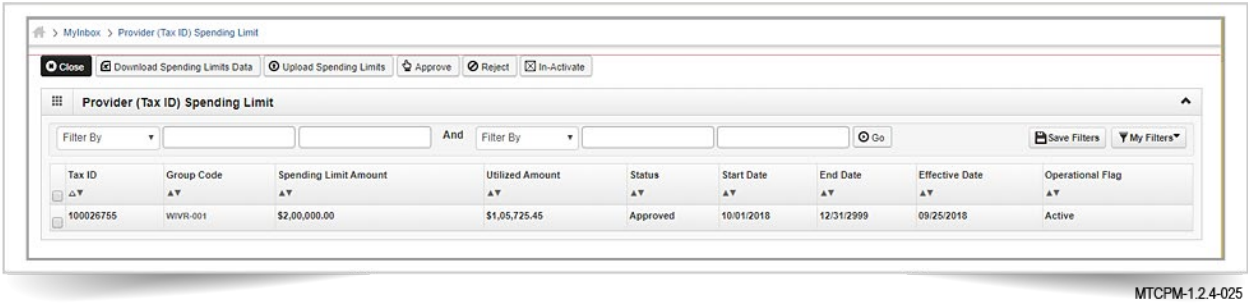


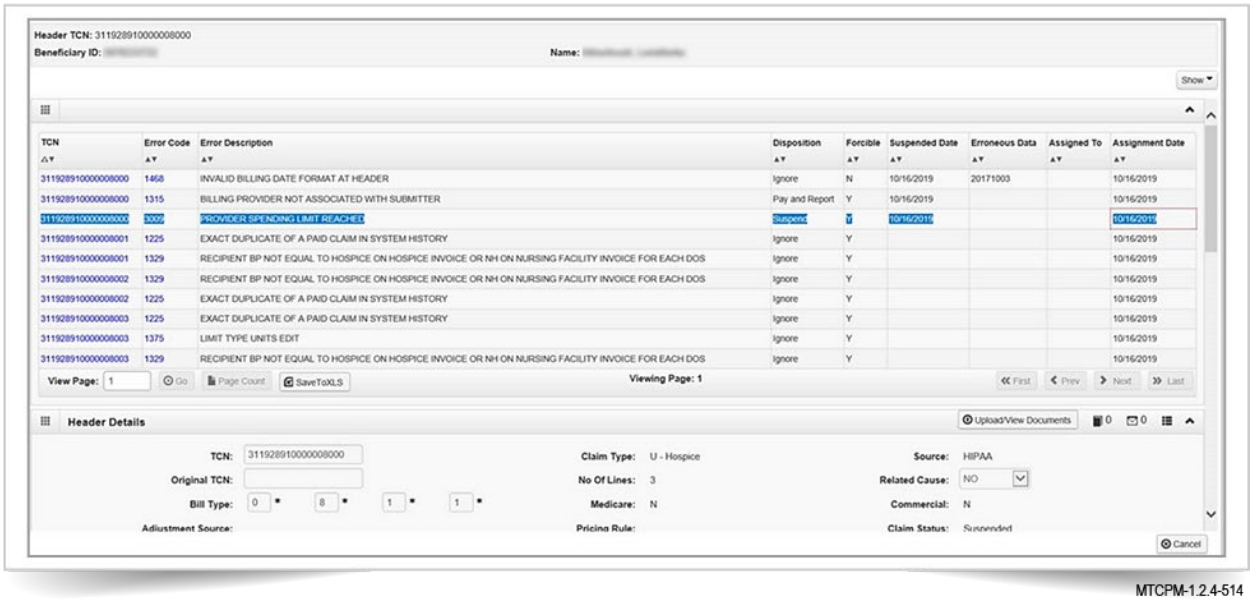
Figure 3.10.11-63. This screen shows where users capture spending limits based on Provider/Tax ID.

PP49

The Contractor's solution shall, upon reaching the threshold amount for program or waiver claims, reimburse on a pro-rated basis until the expenditure allowance is reached. Once the maximum expenditure threshold is met, then pay no further claims.

Team CNSI can customize the evoBrix X Core Claims module to establish expenditure threshold limits and reimburse claims on a pro-rated basis. Once a threshold is reached, our solution ensures that no further claims are paid. Users can set up and edit a spending limits definition, as shown in Figure 3.10.11-64. Users can also establish spending limits by provider with a group definition, which identifies the specific waiver service for which they applied the limits.

Our solution flags claims that match pre-determined criteria for use. Based on the utilization limit, our solution's rules engine includes edits to deny claims, which Team CNSI reports in a RA.



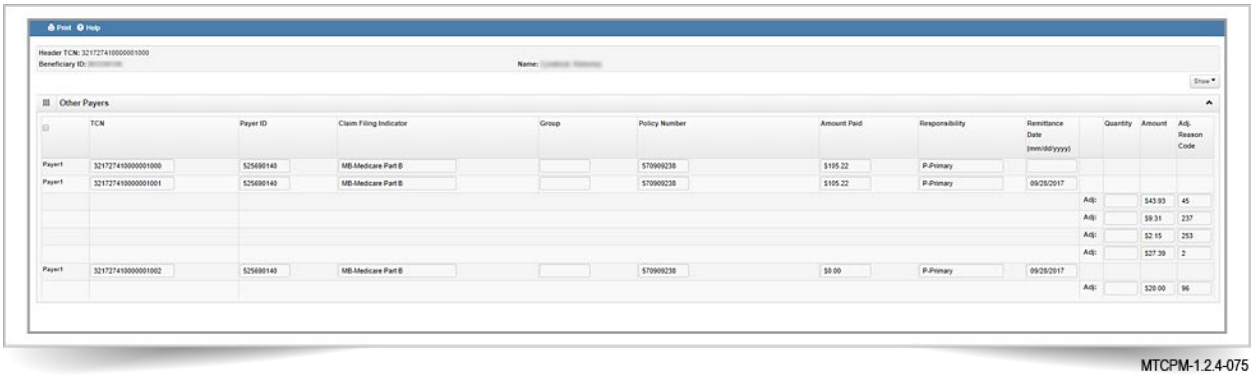
MTCPM-1.2.4-514

Figure 3.10.11-64. The Claim Error screen displays an edit posted for a provider that reaches its spending limits.

PP50

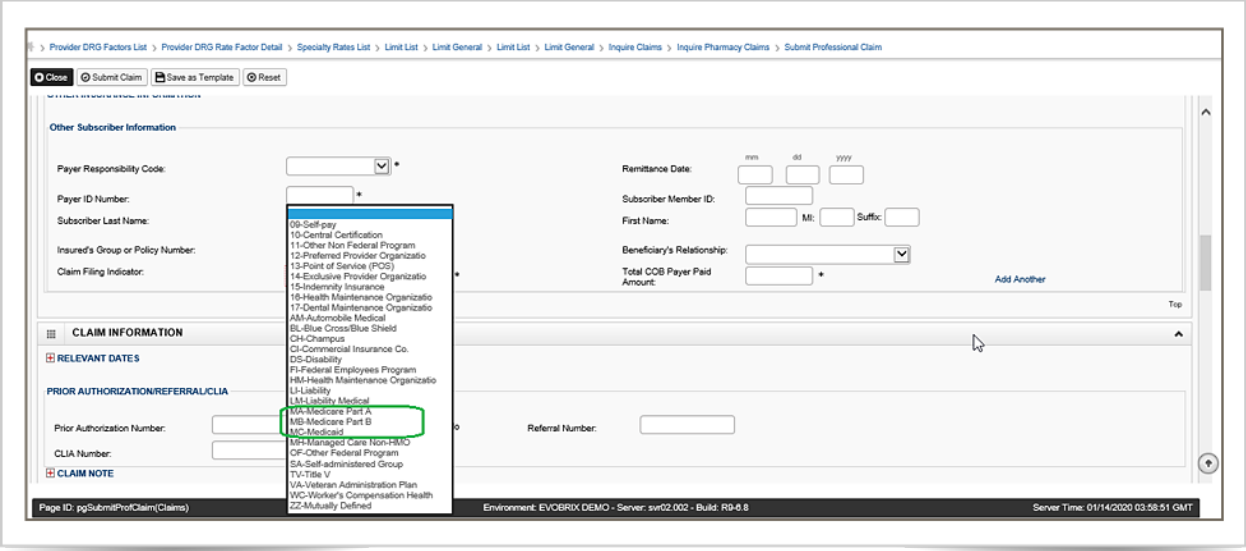
The Contractor's solution shall receive, maintain, and store all Medicare Part A, B, and D claims payment information as specified by the Agency.

The evoBrix X Core Claims module processes Medicare crossover claims and claims from providers with Medicare as an additional insurance payer per DPHHS requirements. Our solution receives, maintains, and stores Medicare coverage and claims payment information in another payer segment with the claim information, as shown in Figure 3.10.11-65. We adjudicate claims taking the Medicare payment established within the pricing rules under consideration, which we can extend based on DPHHS policies. See Figure 3.10.11-66 and Figure 3.10.11-67 for more information.



MTCPM-1.2.4-075

Figure 3.10.11-65. This screen displays Medicare payment information as well as a caption.



MTCPM-1.2.4-769

Figure 3.10.11-66. Our solution receives, maintains, and stores Medicare Part A, B claims payment information.



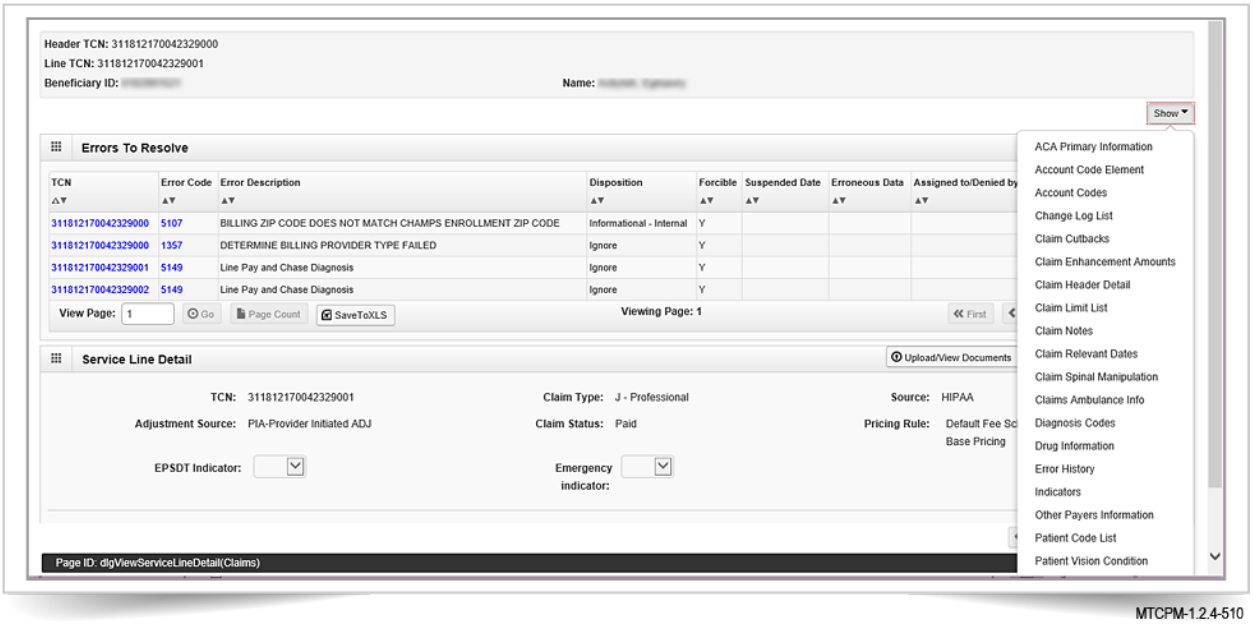
MTCPM-1.2.4-770

Figure 3.10.11-67. Our solution receives, maintains, and stores Medicare Part D payment information.

PP51

The Contractor's solution shall capture, store, maintain, update, display, and report all claim processing activity (e.g., adjudication status, suspended claims by status and location, claims origin, adjustments, pre-adjudication validation, payment status) as defined by the Agency.

The evoBrix X Core Claims module captures, stores, maintains, updates, displays, and reports all claim processing activities. Our solution tracks the amount of cycles that an adjudicated claim requires before being finalized. Key data elements like the adjustment source, pricing methodology, claim source, adjudication status, and claim type determined are available in the claim header or claim line screen, as shown in Figure 3.10.11-68. Additional data elements related to adjudication are made available in subsequent pages through show menu items.



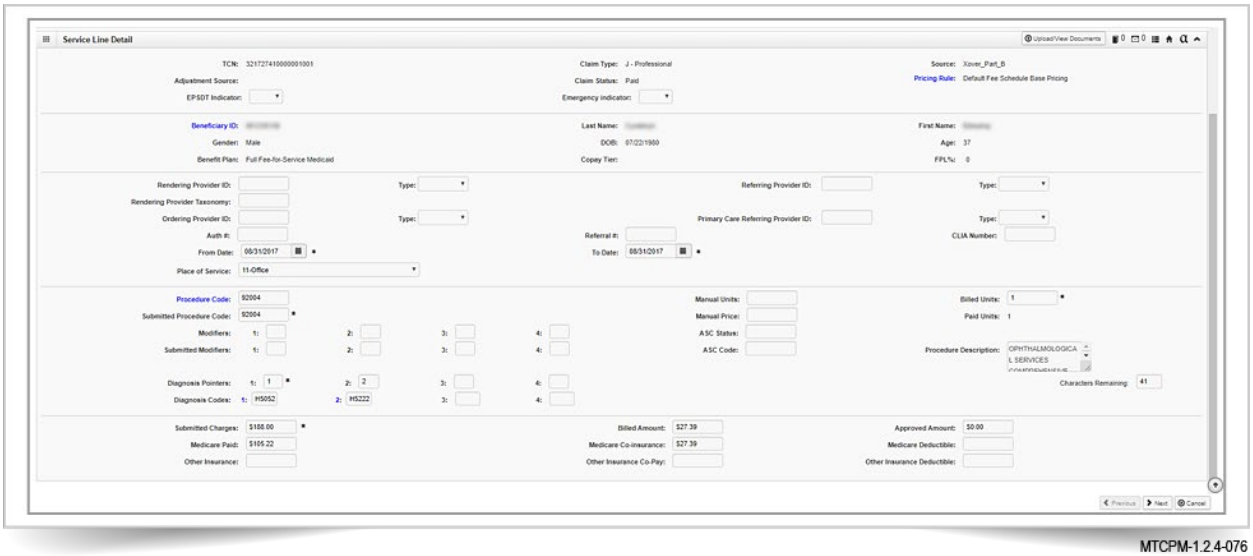
MTCPM-1.2.4-510

Figure 3.10.11-68. This Claims screen displays data elements as well as a caption.

PP52

The Contractor's solution shall adjudicate crossover claims at the detailed line item or header level based on Agency configurable business rules.

The evoBrix X Core Claims module accepts and adjudicates Medicare crossover claims at the detailed claim line item or claim header level based on standard pricing rules and according to DPHHS requirements. The standard pricing rules include a specific "lesser of" logic to determine that the Medicaid payment amount is lower than a Medicare patient's responsibility, the Medicaid allowable amount, and the difference between the Medicare paid amount and the Medicaid allowable amount. See Figure 3.10.11-69 and Figure 3.10.11-70 for more information.



MTCPM-1.2.4-076

Figure 3.10.11-69. This screen displays line level pricing with Medicare cross over information.

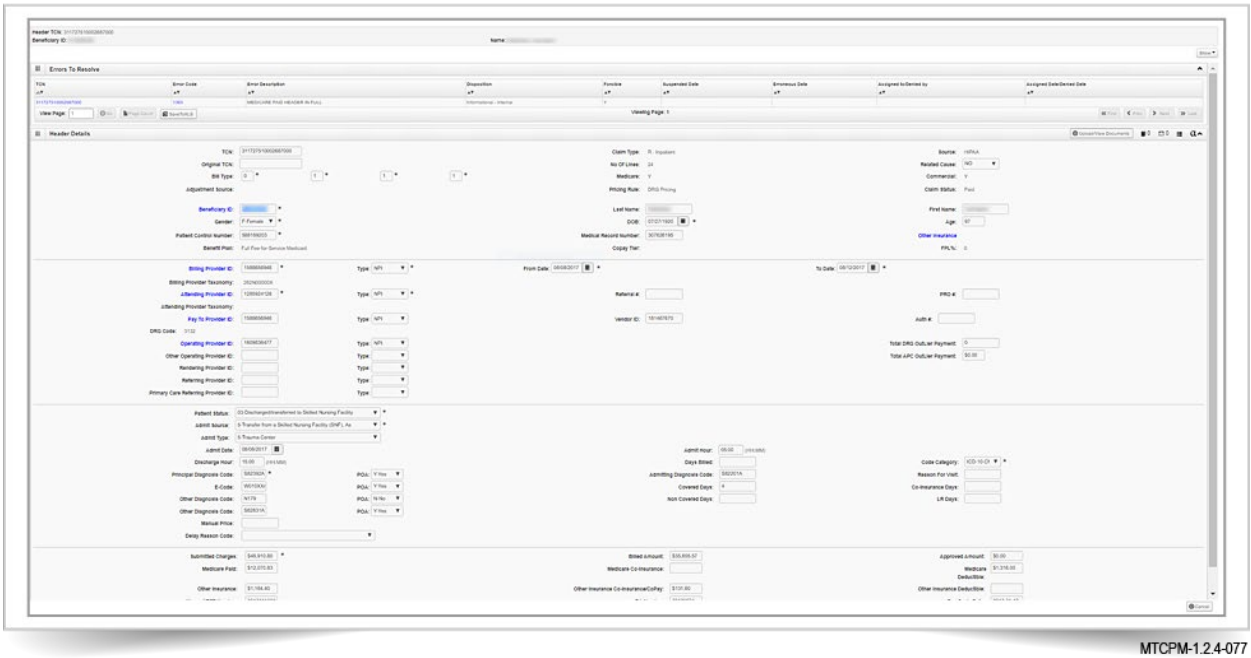


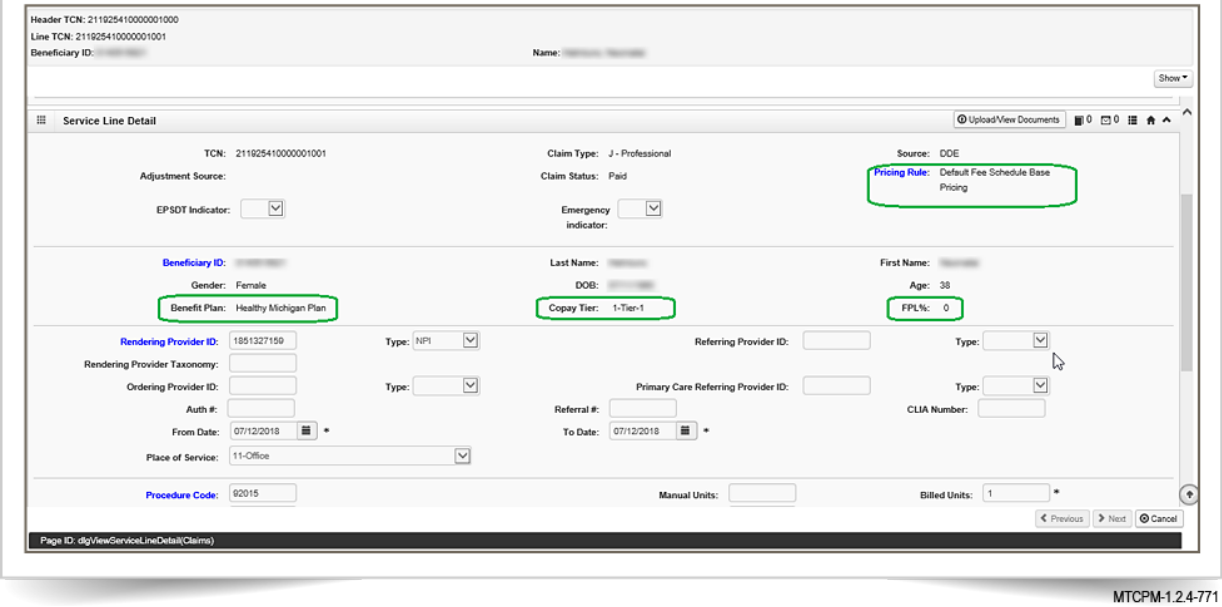
Figure 3.10.11-70. This screen displays header level pricing with Medicare cross over information.

PP53

The Contractor's solution shall accurately calculate based on Agency configurable business rules, allowable reimbursement criteria for each service according to date specific rules and limitations applicable to each claim and encounter type, including service, pricing modifiers (multiple), benefit plan, category of service, and provider type/specialty in accordance with program policy established by the Agency.

Team CNSI's evoBrix X CPMS solution accurately calculates the payment amount for each service line on a claim based on the applicable rules and criteria for the claim's date(s) of service and DPHHS requirements. Our solution stamps the pricing methodology on the claim to ensure easy identification.

Pricing rules defined in the RuleIT platform are date driven, which creates the flexibility to establish a specific rule version at a future date if necessary. This feature enables authorized DPHHS users to customize Agency-specific business rules and promote it to production for future processing, without affecting the current functionality. Once our solution reaches the targeted future date, it automatically applies the rules against the date of service. See Figure 3.10.11-71 for more information.



MTCPM-1.2.4-771

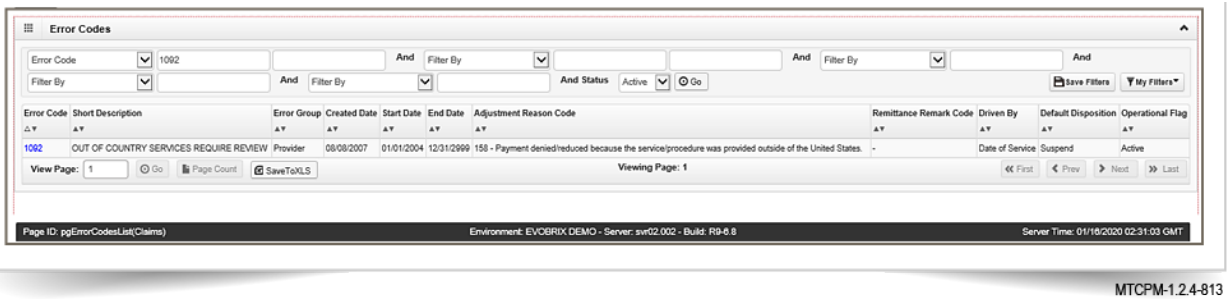
Figure 3.10.11-71. This screen displays claims that are accurately calculated based on configurable pricing rules and allowable reimbursement criteria.

PP54

The Contractor's solution shall provide automated processing logic to price out-of-state claims (e.g., local rate, percent of charges, or suspend for manual pricing) based on configurable business rules defined by the Agency.

The evoBrix X Core Claims module offers different automated processing logics to price out-of-state claims per DPHHS requirements. Our solution's rules engine can suspend and flag out-of-state providers. Rules are then set up for local rates, percent of charges, and per-diem rates. We can also enhance pricing rules defined in the RuleIT platform to handle DPHHS-specific business rules for out-of-state claims processing. In addition, we can suspend out-of-state claims for manual review per DPHHS business rules. Team CNSI can customize our solution to meet DPHHS-specific automated processing rules.

Figure 3.10.11-72 shows where users can edit out-of-state claims for manual pricing.



MTCPM-1.2.4-813

Figure 3.10.11-72. Users can edit out-of-state claims for manual pricing on this screen.

PP55

The Contractor's solution shall allow payment to fee-for-service providers for services rendered to members in pre-enrollment periods or other periods of transition (e.g., presumptive eligibility) based on configurable business rules defined by the Agency.

The evoBrix X Core Claims module allows payments to FFS providers for services rendered to members in pre-enrollment periods or other periods of transition. We designed our solution to identify member eligibility following receipt of information from the Medicaid Eligibility Determination system through the ISR. Member eligibility is determined during claim adjudication and we apply and price appropriate benefit service packages according to a pricing hierarchy defined by DPHHS. Figure 3.10.11-73 shows how our solution makes payments FFS providers during pre-enrollment periods.

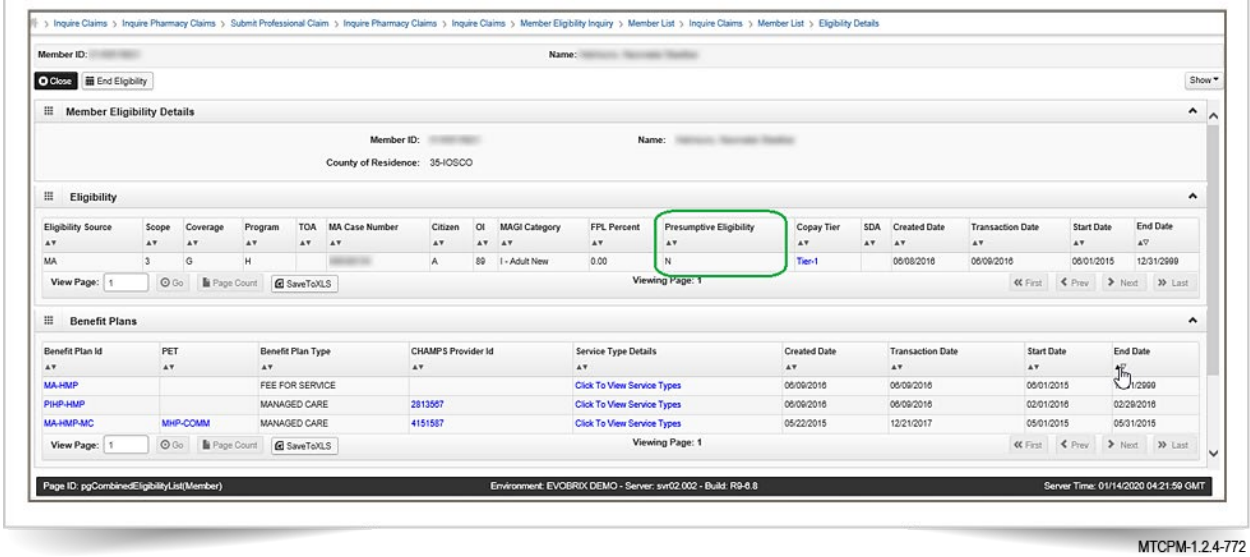


Figure 3.10.11-73. This screen displays a payment to a FFS provider for services rendered to members in a pre-enrollment period.

PP56

The Contractor's solution shall produce and maintain state-specific companion and user guides, payer sheets, and/or fee schedule as directed by the Agency.

Team CNSI's evoBrix X CPMS solution produces, maintains, and documents State-specific companion and user guides, payer sheets, and/or fee schedules for each X12 transaction. We create an Electronic Submission Manual (ESM) document as a user guide, which provides information for providers and entities on how to handle electronic transactions from DPHHS.

Team CNSI also generates a payer sheet, which providers and billing agents use to identify the appropriate Payer ID for a claim transaction. The evoBrix X Core Claims module includes pre-defined reports to generate fee schedules, which Team CNSI includes in the ESM. DPHHS-specific business rules are also applied to a fee-schedule report to ensure providers submit appropriate claims.

Team CNSI maintains similar companion guides, payer sheets, and a fee schedule for the states of Michigan and Washington, which we can leverage in support of the MT CPMS project.

PP57

The Contractor's solution shall provide pricing methodologies as defined by the Agency and compliant with 42 CFR 447 to include, but not limited to:

a) provider contracted rates

b) CPT/HCPS/CDT and modifier codes

c) fee schedule for the corresponding date

d) RBRVS claims

e) Manual pricing

f) Place of service

g) Specialty type

h) Pay by report

i) Age range

j) Category of service

k) CDT procedure code fee schedule

l) Revenue codes

m) APR-DRG (Diagnosis-Related Group)

n) APG

o) Per Diem at provider specific rates

p) Add-on pricing amounts to any pricing structures based on other claim attributes (e.g. service facility, provider type/specialty, place of service etc.)

q) Provider specific encounter rate

r) Variable percentage of billed charge

s) Variable percentage based on provider type (FQHC, RHC, IHSp)

t) PMPM with line level detail

u) Medicare's Outpatient Prospective Payment System

v) Bundled/unbundled pricing

w) Global service pricing

x) Calculation required for resource-based relative value system fee schedule for radiology, anesthesia, and general medical services

y) Tiered pricing into which a variety of services are grouped depending on the treatment type and intensity of care required

z) Invoicing pricing (e.g., plus/minus percentage, procedure code)

aa) Geographic designation

bb) Lab pricing

cc) Special pricing based on time (e.g. anesthesia)

dd) Medicare crossover claims

ee) Cost to charge percentage

ff) Maximum of inpatient charges

gg) Radiology codes with multiple components

Team CNSI's evoBrix X CPMS solution applies DPHHS-specified claim data elements and pricing methodologies defined in the RFP to compute claim reimbursement. We currently process more than 162

million claims per year using our evoBrix X CPMS solution. Our pre-configured pricing methods ensure timely filing, prompt payment, and accurate reimbursements in compliance with 42 CFR 447.

Our proposed solution is pre-configured to price claims and compute claim reimbursement based on varied pricing rules, which we describe in the following paragraphs.

Professional Claims: Our solution applies contracted rates with providers to price professional claims per the fee schedule. We configured our solution to apply the rates for practitioners, medical suppliers, and other professionals as established by DPHHS.

Our solution supports pricing by multiple fee schedules for professionals, including a resource-based relative value system for radiology, anesthesia, and general medical services. In addition, it accommodates any annual updates to the practitioner fee schedule based on the CMS-released Resource Based Relative Value Scale (RBRVS), ambulance services, lab services fee schedules, and any additional state-specific Medicaid fee adjustments.

Fee schedule pricing logic contains rules that retrieve provider-contracted rates and CPT4/HCPCS procedure code rates. Our solution uses a combination of procedure codes and modifiers to derive the fee schedule rate. The evoBrix X Core Claims module supports modifier pricing, which can occur either by a code to the modifier entry in the reference file or through charge mode rates. It allows modifier pricing based on both a percentage of the fee schedule and on an additional rate applied based on the charge mode rate. The Core Claims module can also execute pricing rules set in pre-defined configurable sequences when multiple sets of rules apply to a single service line.

Team CNSI performs manual pricing when no fee schedules are available or when we receive a request from a claims resolver to manually price a specific service.

Dental Claims: The evoBrix X Core Claims module uses indicators on the billing provider enrollment record and contracted rates with providers to price dental claims per the current dental terminology (CDT) fee schedule. Fee schedule pricing logic contains rules that retrieve provider-contracted rates and procedure code rates from the Benefits Administration component within the Core Claims module.

The evoBrix X Core Claims module can also execute pricing rules set in pre-defined configurable sequences when multiple sets of rules apply to a single service line. Our solution performs manual pricing when no fee schedules are available.

Institutional In-Patient Claims: We pre-configured our evoBrix X CPMS solution to leverage APR-DRG 3M groupers for inpatient pricing. The pricing methods leverage the following data elements to calculate the final inpatient paid amount at a claim header level:

- DRG rate factors (e.g., DRG code, Relative Weight, Length of stay).
- Provider DRG factors (e.g., DRG base rate, operating ratio, skilled days, discharge rate)
- Provider rates (Revenue codes for room and board)

We also configured our solution to price claims on the per diem rate on provider contracts, instead of routing the claim to the DRG grouper, for those providers without DRG assignment (e.g., nursing facilities, hospice, psychiatric residential treatment facilities, and rehabilitation hospitals). The evoBrix X Core Claims module supports pricing of long-term care claims and hospice claims based on room and board charges and other services. Details such as the capacity of the provider's inpatient facility are also factored into the pricing. Users can retrieve this information from the evoBrix X Core Claims module to facilitate the pricing process.

Institutional Out-Patient Claims: Our solution prices outpatient claims at the service line level. Claims are identified for Outpatient Prospective Payment System (OPPS) pricing using claim type and provider indicators as well as the revenue fee schedule. The solution leverages OPPS and Ambulatory Payment

Classifications (APC)-related editing and pricing using HSS APC software for outpatient claims. This includes services rendered in hospital outpatient departments, ambulatory surgery centers, and outpatient therapy providers (e.g., comprehensive outpatient rehabilitation facilities). We also regularly apply quarterly updates published by Medicare related to OPPS/APC methodology, pricing, and editing.

We configured our solution to price claims at provider-specific rates, such as the encounter rate established using a clinic's current prospective payment system (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) or the Indian Health Service all-inclusive rate (AIR) methodology for Tribal Health Centers (THC). Our solution processes the encounter rate based on the encounter revenue code and detail line item combination and posts the payment on the encounter service line. The pricing logic includes the flexibility to validate the number of daily encounters received from the provider for the same member, along with the diagnosis.

Add-on Pricing. Crossover claims pricing applies to all invoice types and, as such, the evoBrix X Core Claims module is pre-defined to handle it. The evoBrix X Core Claims module enhances or decreases the payment amount based on defined parameters in add-on pricing. Our solution handles bundling and unbundling of services, which is supported by NCCI limits editing.

Team CNSI's solution provides pricing methodologies as shown in Figure 3.10.11-74. We will customize our solution to maintain a geographic designation, cost to charge percentage, and radiology codes with multiple component detail code sets.

Features	Benefits
Professional Claims – (priced at the service line level) a) provider contracted rates b) CPT/HCPS/CDT and modifier codes c) fee schedule for the corresponding date	The evoBrix X CPMS solution uses indicators on the billing provider record and the provider contracted rates to price Professional Claims per the fee schedule. The evoBrix Core Claims module supports modifier pricing, which can occur either by a code to the modifier entry in the reference file or through charge mode rates; it allows modifier pricing based on both a percentage of the fee schedule and on an additional rate applied based on the charge mode rate.
d) RBRVS claims x) Calculation required for resource-based relative value system fee schedule for radiology, anesthesia, and general medical services bb) Lab pricing cc) Special pricing based on time (e.g. anesthesia)	We configured our evoBrix X CPMS solution to price claims for radiology, anesthesia, and general medical services based on resource-based relative value system fee schedule. The system accommodates any annual updates to the Practitioner Fee Schedule based on CMS-released RBRVS, lab services' fee schedules, and any additional state-specific Medicaid fee adjustments.
e) Manual pricing	The evoBrix X CPMS solution suspends claims for manual pricing based on the "Manual Price" indicator on service codes. When no pricing fee schedules are available, our solution posts an edit for manual pricing based on DPHHS business rules.
f) Place of service g) Specialty type i) Age range j) Category of service	We accomplish the maintenance of benefit plans, limits, and rates by using evoBrix X Core Claims module application screens. Benefit plan setup screens allow authorized users to define the parameters using the restrictions feature. We can configure place of service, specialty type, and age range as restriction parameters. Our solution allows users to add category of service through procedure codes, diagnosis codes, benefit limitations, provider exclusions, eligibility criteria, effective dates, and member cost sharing.
h) Pay by report	Team CNSI's evoBrix X Core Claims module can be set up to remove the duplicate member records on the PMPM payment report. The business rules to identify potential duplicate data conflicts are configurable. Based on Agency policies and rules, we can establish appropriate actions to ensure our solution considers only unique members for the additional

Features	Benefits
	PMPM case management fee payment.
k) CDT procedure code fee schedule	The evoBrix X Core Claims module uses indicators on the billing provider enrollment record and contracted rates with the providers to price dental claims per the current dental terminology (CDT) fee schedule. Fee schedule pricing logic contains rules that retrieve provider contracted rates and procedure code rates from the Benefits Administration component within the Core Claims module.
l) Revenue codes m) APR-DRG (Diagnosis-Related Group) n) APG o) Per Diem at provider specific rates	We pre-configured our evoBrix X CPMS solution to leverage APR-DRG 3M grouper for Inpatient pricing. The pricing methods leverage data elements defined below to calculate the final Inpatient paid amount at a claim header level: ■ DRG rate factors (e.g., DRG code, Relative Weight, Length of stay). ■ Provider DRG factors (e.g., DRG base rate, operating ratio, skilled days, discharge rate) ■ Provider rates (Revenue codes for room and board) We also configured our solution to price claims on the per diem rate on provider contracts, instead of routing the claim to the DRG grouper, for those providers without DRG assignment. This includes providers such as nursing facilities, hospice, psychiatric residential treatment facilities. and rehabilitation hospitals. The evoBrix X Core Claims module supports pricing of long-term care claims and hospice claims based on room and board charges and other services. Details such as the capacity of the provider's inpatient facility also play a role during pricing. Users retrieve his information from the evoBrix X Core Claims module to facilitate the pricing process.
p) Add-on pricing amounts to any pricing structures based on other claim attributes (e.g. service facility, provider type/specialty, place of service etc.)	Crossover claims pricing applies to all invoice types and, as such, we pre-defined the evoBrix X Core Claims module to handle it. The Core Claims module enhances or decreases payment amounts based on defined parameters in add-on pricing. Our solution handles bundling and unbundling of services and is supported by NCCI limits editing.
q) Provider specific encounter rate r) Variable percentage of billed charge s) Variable percentage based on provider type (FQHC, RHC, IHSp)	We configured our solution to price claims at provider-specific rates, such as the encounter rate established using the clinic's current prospective payment system (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) or the Indian Health Service all-inclusive rate (AIR) methodology for Tribal Health Centers (THC). Our solution processes the encounter rate based on the encounter revenue code and detail line item combination, with the payment being posted on the encounter service line. The pricing logic includes the flexibility to validate the number of encounters received in a day from the provider for the same member, along with the diagnosis.
u) Medicare's Outpatient Prospective Payment System	Team CNSI's evoBrix X CPMS solution prices outpatient claims at the service line level. Outpatient Prospective Payment System (OPPS) pricing identifies claims using claim type and provider indicators and the Revenue Fee Schedule. The solution leverages OPPS and Ambulatory Payment Classifications (APC)-related editing and pricing using HSS APC software for outpatient claims. This includes services rendered in Hospital outpatient departments, Ambulatory Surgery Centers, and Outpatient therapy providers such as Comprehensive Outpatient Rehabilitation Facilities. Quarterly updates published by Medicare related to OPPS/APC methodology, pricing, and editing are regularly applied.
t) PMPM with line level detail	The evoBrix X CPMS solution can generate PMPM payments with both claim header and claim line level details using configurable service sources.
v) Bundled/unbundled pricing	Team CNSI configures the edits that are bundled in the RuleIT platform. We have currently defined bundling edits for lab services. We will define

Features	Benefits
w) Global service pricing	additional bundling edits, per Agency requirements, using online configurable screens of bundle groups. The evoBrix X Core Claims module includes standard pricing methodology rules to handle global services, i.e., surgical pricing. Surgical pricing (e.g., bariatric surgery, surgical services, surgery, pre- and post-op, prenatal) applies a RVU configuration to determine the appropriate rate adjustment to be applied on the base rate of primary procedure code. Surgical pricing rules determine the primary procedure and other procedures based on National Correct Coding Initiative (NCCI) editing and bundled services.
y) Tiered pricing into which a variety of services are grouped depending on the treatment type and intensity of care required	We will configure our evoBrix X CPMS solution to price and process claims using the Level of Care/Tiered Pricing method. Once set up, we can configure the business rules based on treatment type and intensity of care required.
z) Invoicing pricing (e.g., plus/minus percentage, procedure code)	Our solution performs COB pricing when it receives relevant data in a claim transaction. This includes the logic to compute the Medicaid payment amount to be the lower of Medicare patient responsibility amount or the difference between the Medicare payment and the allowed Medicaid payment amount.
aa) Geographic designation	Team CNSI's evoBrix X solution can support rates based on postal codes.
dd) Medicare crossover claims	Team CNSI's evoBrix X solution supports receipt and processing of Medicare crossover claims. We configure special rules in the RuleIT platform to process these claims. This includes the logic to compute the Medicaid payment amount to be the lower of Medicare patient responsibility amount or the difference between the Medicare payment and the allowed Medicaid payment amount.
ee) Cost to charge percentage	Team CNSI's evoBrix X solution can store and maintain cost to charge percentages.
ff) Maximum of inpatient charges)	We pre-configured our solution to check for cost share limits for the individual and family during claim adjudication. Benefit plan cost sharing allows a user to add or modify member premium, copayment, deductible, coinsurance, and out-of-pocket maximums. We maintain a "Cost Share Met" flag in our solution at the individual and family level. We reset the "Cost Share Met" flags every quarter/month based on State policy.
gg) Radiology codes with multiple components	Team CNSI's evoBrix X solution can store and maintain radiology codes with multiple components for pricing the claim.

Figure 3.10.11-74. Features and Benefits of CNSI's Pricing Methodologies.

Figure 3.10.11-75 through Figure 3.10.11-77 Figure 3.10.11-77. This screen shows a provider DRG rate factor with per diem pricing.provide information regarding pricing methodologies to compute claim reimbursements.

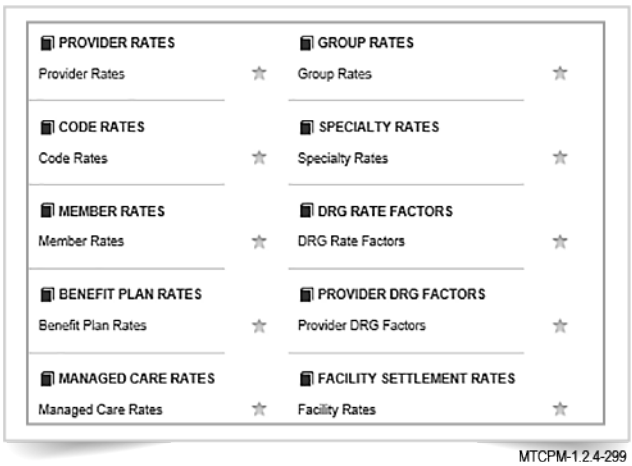


Figure 3.10.11-75. Pricing methodologies as defined and compliant with 42 CFR 447.

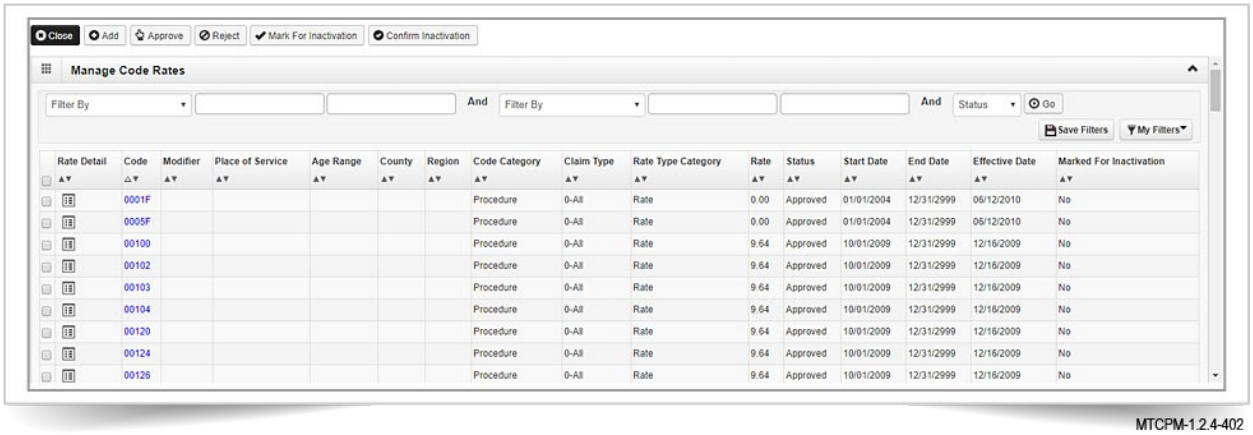


Figure 3.10.11-76. This screen shows code rates with modifier, age range, claim type, rate category, and place of service.

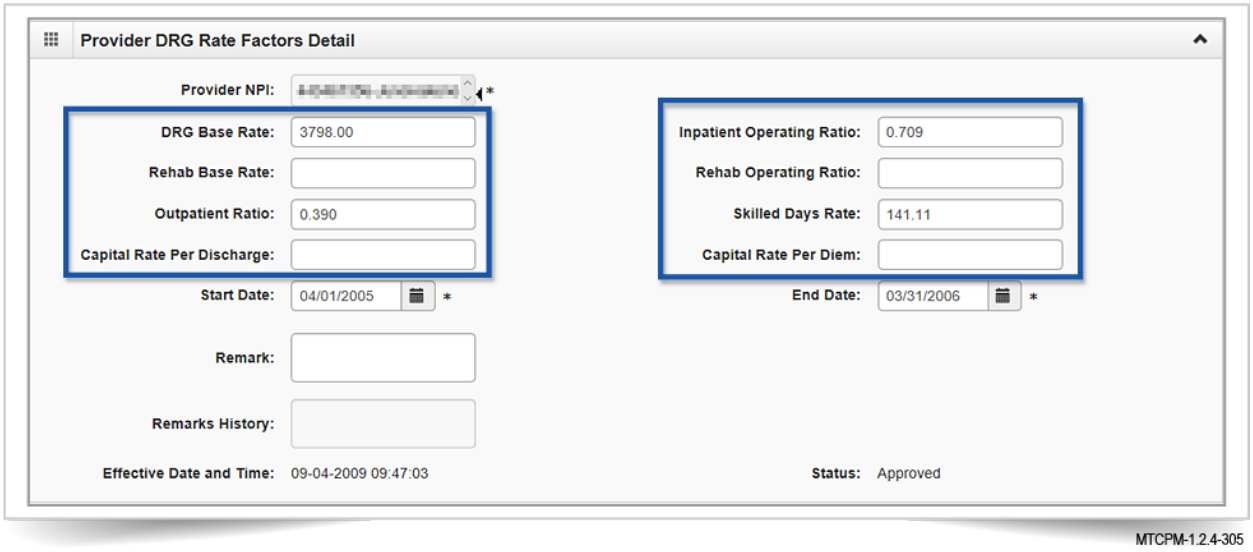


Figure 3.10.11-77. This screen shows a provider DRG rate factor with per diem pricing.

PP58

The contractor solution shall identify, accept, adjudicate, and store claims (e. g. medical inpatient, outpatient, crossover) submitted with procedure codes for physician administered drugs and require and capture the corresponding NDC.

The evoBrix X Core Claims module identifies, accepts, adjudicates, and stores claims with J-code service lines on medical claims with the NDC code as shown in Figure 3.10.11-78. We store the NDC codes in our solution with the respective service line. Our solution maintains HCPCS-NDC crosswalk drug files received from the PBMS system through ISR. A HCPCS-NDC crosswalk provides additional data element required for J-Code quantity drug rebates, along with effective dates to adjudicate claims and price them based on the pricing rules defined by DPHHS.

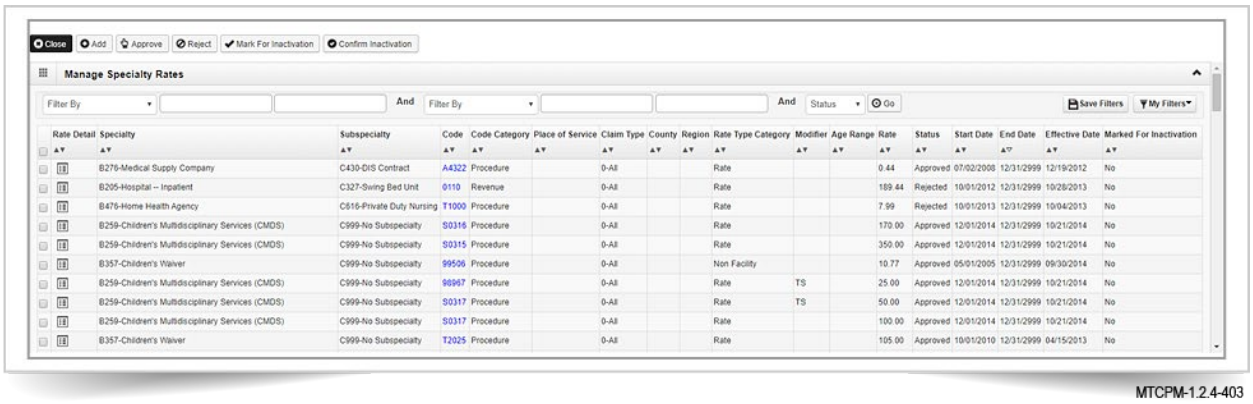


Figure 3.10.11-78. This screen depicts a sample of a priced J-Code claim with a caption.

PP59

The Contractor's solution shall capture, store, maintain, and send the data required to invoice manufacturers for the drug rebate including any adjustments or credits to the claim as defined by the Agency.

Team CNSI's evoBrix X CPMS solution captures, stores, maintains, and sends data required to invoice manufacturers for a drug rebate, including any adjustments or credits to the claim, per DPHHS requirements. Our solution stores and maintains the HCPCS/NDC crosswalk drug file with quantity drug rebates, along with effective dates. Medical claims are also stored with J-Code service line and submitted NDC codes. We maintain data in our solution and pass it to the electronic data warehouse for archival. Based on the data from the NDC crosswalk and the claims data, our solution can also generate drug rebate invoices for manufacturers. See Figure 3.10.11-79 for more information.

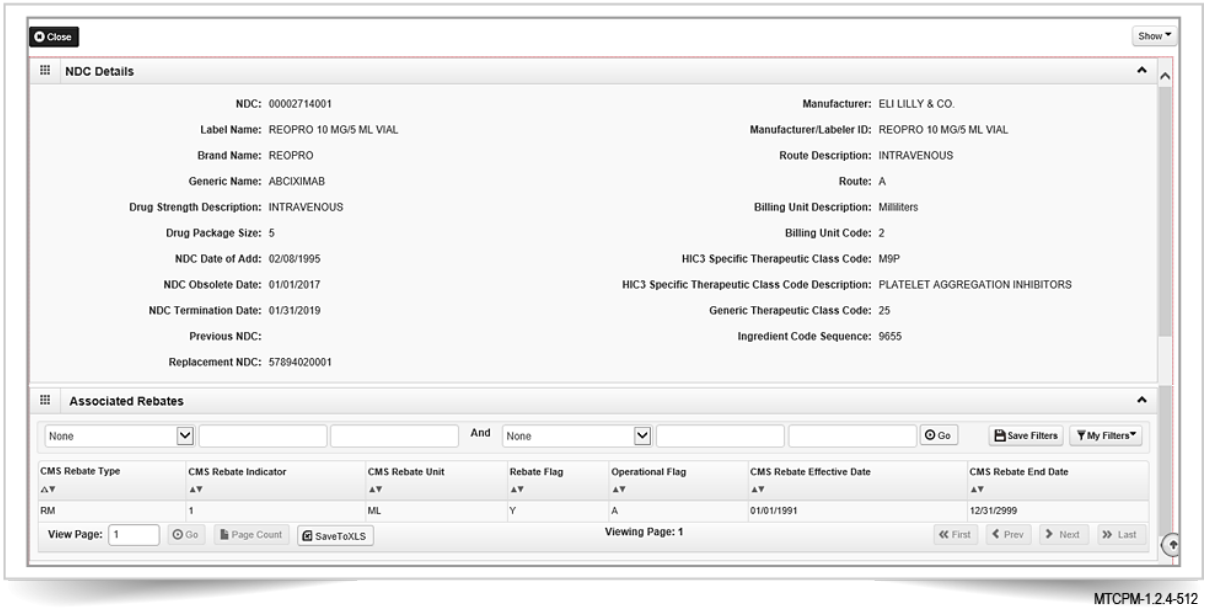


Figure 3.10.11-79. This NDC Detail screen includes rebate details.

PP60

The Contractor's solution shall have automated pricing logic to convert time measurement units into the correct dollar value for payment (e.g., anesthesia)

Team CNSI defined the inbuilt pricing rules within the evoBrix X Core Claims module to convert time measurements to claim units in order to price services based on rate setup. Conversion factors of time measurements are static configurable within our solution. As a result, we can define the parameters based on DPHHS requirements. For example, Team CNSI's pre-defined anesthesia pricing rules use time measurements of 15 minutes as one unit of service. We can extend this rule to use different time measurements based on criteria such as Medicare covered services.

Figure 3.10.11-80 shows part of an anesthesia pricing rule with a time measure conversion step. Figure 3.10.11-81 shows anesthesia base values defined in the procedure code.

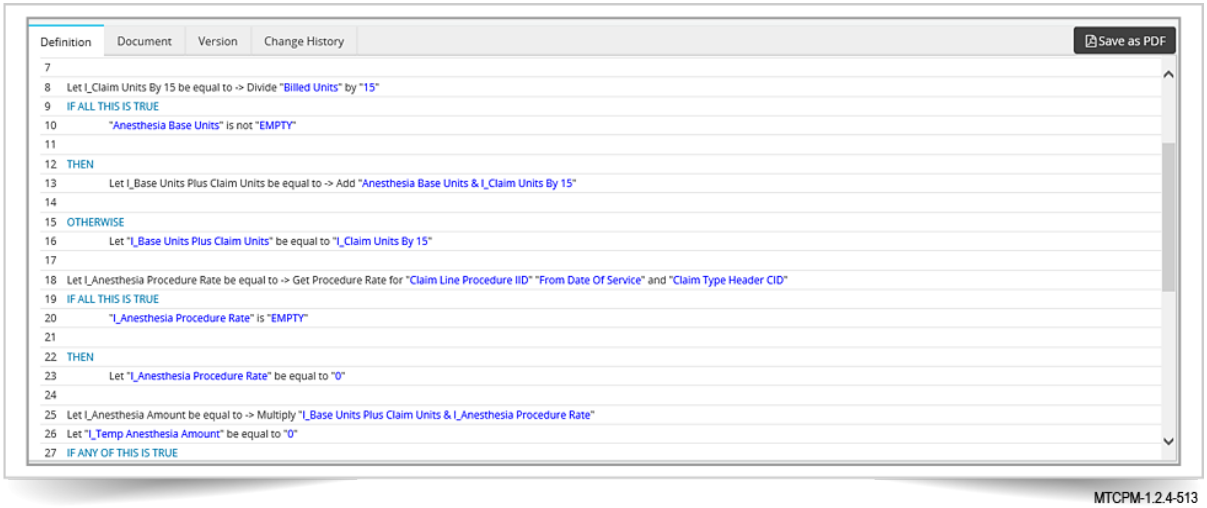


Figure 3.10.11-80. This screen displays a snippet of ab anesthesia time conversion rule with a caption.

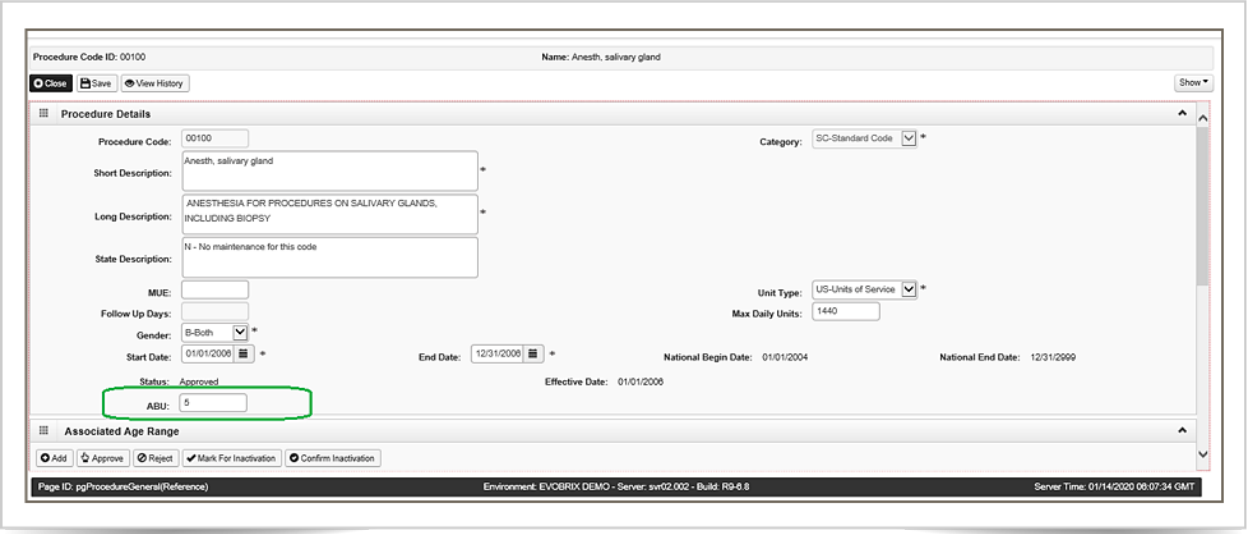


Figure 3.10.11-81. This screen indicates that anesthesia base values are code specific and defined in the procedure code.

PP61

The Contractor's solution shall allow for Payees to receive one payment and remittance advice (or ANSI X12 835) for services provided under one or more benefit plans based on configurable business rules.

The evoBrix X Core Claims module enables payees to receive one payment and RA (or ANSI X12 835) for services provided under one or more benefit plans per configurable business rules. Our solution updates all claim documents with the appropriate check or EFT information received from the SAO. Upon completion, the evoBrix X Core Claims module generates the RA in PDF format. Our solution also generates a HIPAA payment transaction (i.e., ANSI X12 835) file to transmit. The RA documents are archived and made available to providers through the provider portal and to DPHHS online through the evoBrix X Core Claims screens. Based on a payee's RA selection (electronic or paper), payees receive a X12 835 transaction or a printed paper RA accordingly.

Figure 3.10.11-82 and Figure 3.10.11-83 show the RA details. Payees receive X12 835 details using the 835 hyperlinks in this example.

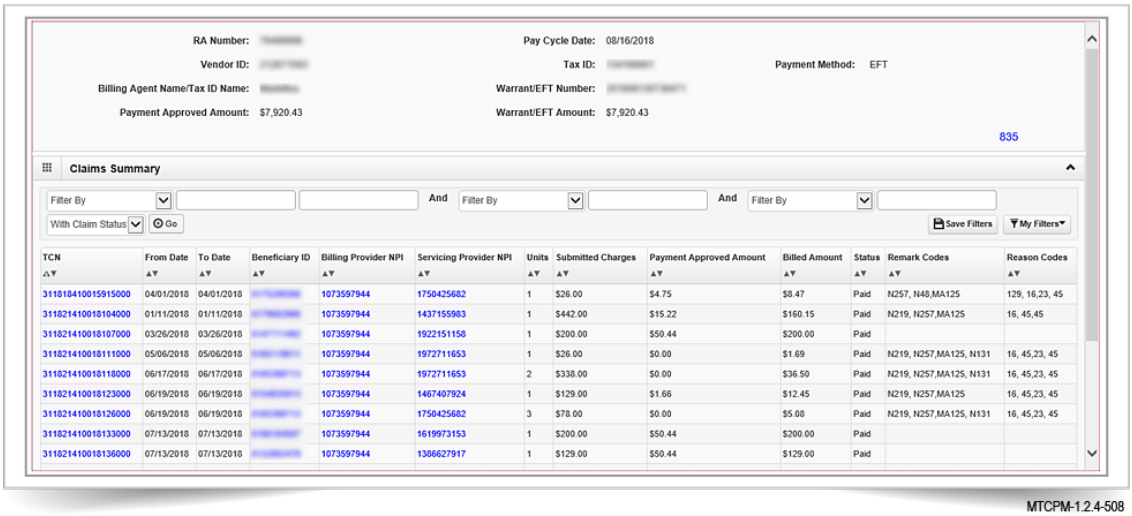


Figure 3.10.11-82. Sample RA. This screen depicts a sample RA that includes X12 835 details.

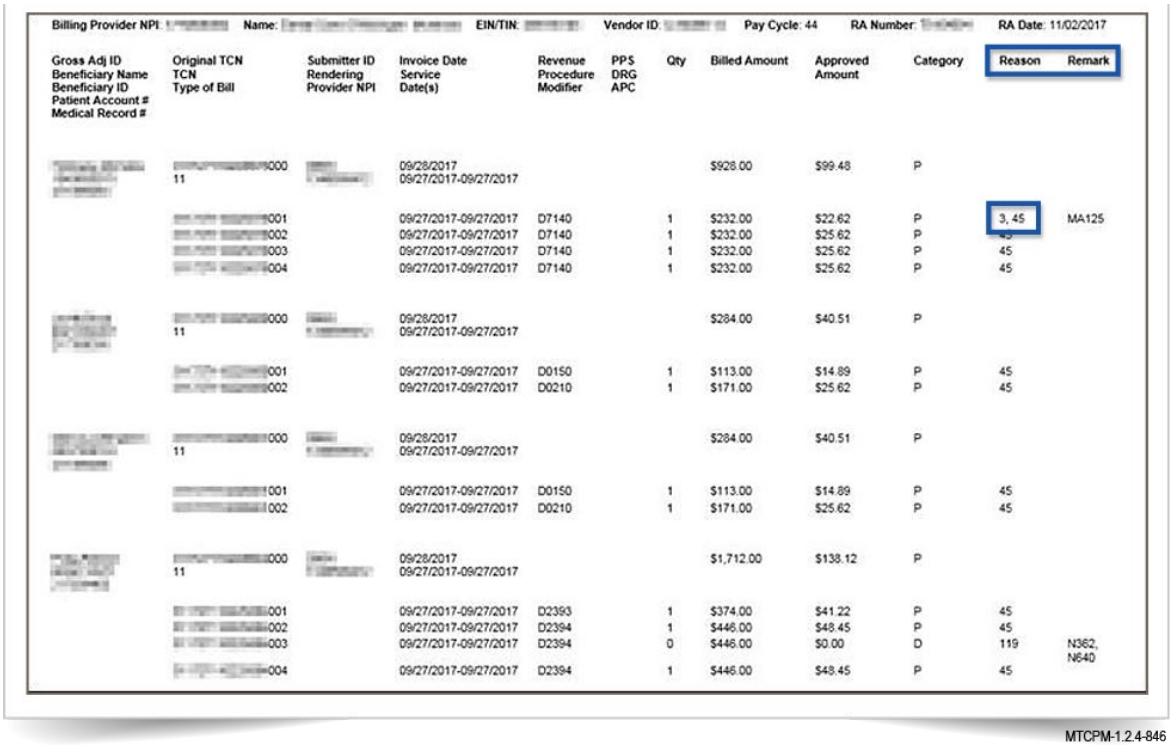


Figure 3.10.11-83. RA in PDF Format. This screen depicts a RA in PDF format.

PP62

The Contractor's solution shall provide bidirectional navigation (drill up/drill down) between the remittance advice and the corresponding financial transaction details.

The evoBrix X Core Claims module maintains accounting ledgers for financial transactions generated from payable claims. Our solution includes bi-directional traceability from a claim to a RA and from a RA to a claim. Financial transactions in accounting ledgers are associated to RAs and claims through SAO invoices and warrants. Figure 3.10.11-84 shows the RA details and the corresponding financial transaction with warrant/EFT number and amount details.

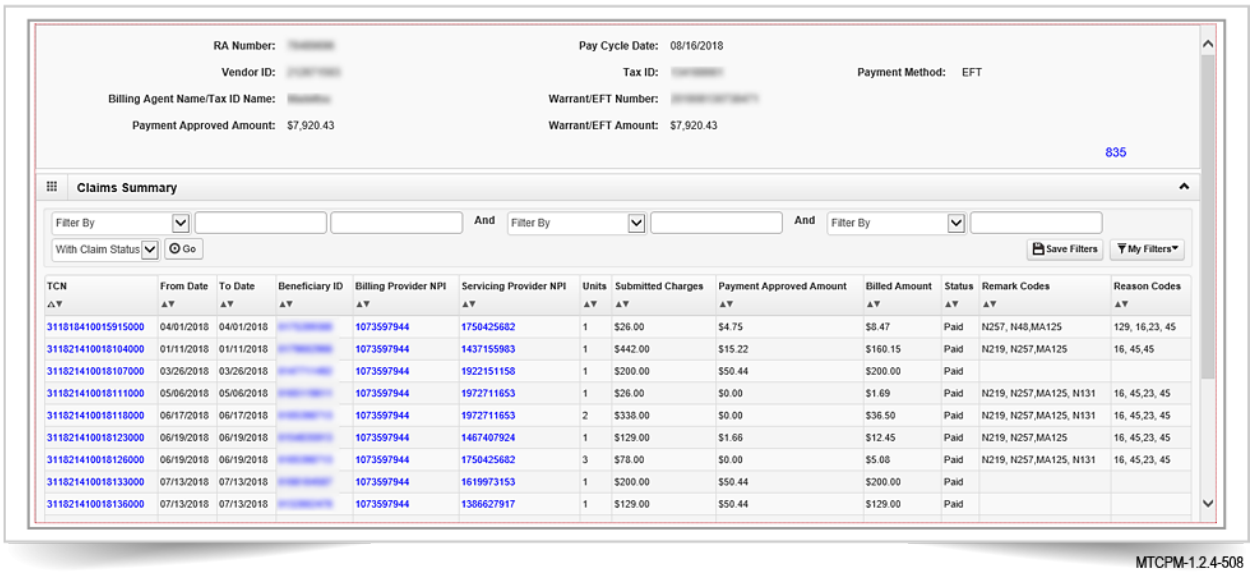


Figure 3.10.11-84. RA with transaction details. This screen depicts a sample RA that includes warrant/EFT number and financial transaction details.

PP63

The Contractor's solution shall automate the claw back process and Medicare accounts payable process based on configurable business rules.

Team CNSI's evoBrix X CPMS solution can identify and configure Medicare Part D dual eligibility members through eligibility files or TPL coverage leads from various sources. Team CNSI will establish Phase-Down Percentages (PD%) and Per Capita Expenditures (PCEs) for the calendar year in our solution. Our solution determines the monthly claw back amount payable and leverages HIPP payment processes with Medicare as the payee to create AP transactions.

PP64

The Contractor's solution shall allow authorized users to manually create accounts payable for HIPP cases, based on configurable business rules.

Team CNSI's evoBrix X CPMS solution includes screens for authorized users to manually create HIPP cases. Once a case is created, the user can assign beneficiary, policy, determined cost effectiveness, premium payment schedule and payee to receive the payment for the HIPP case. Based on the HIPP case setup, payment transactions are generated as a premium payment schedule. Payment transactions are processed once the transactions have been approved using the screen shown in Figure 3.10.11-85.

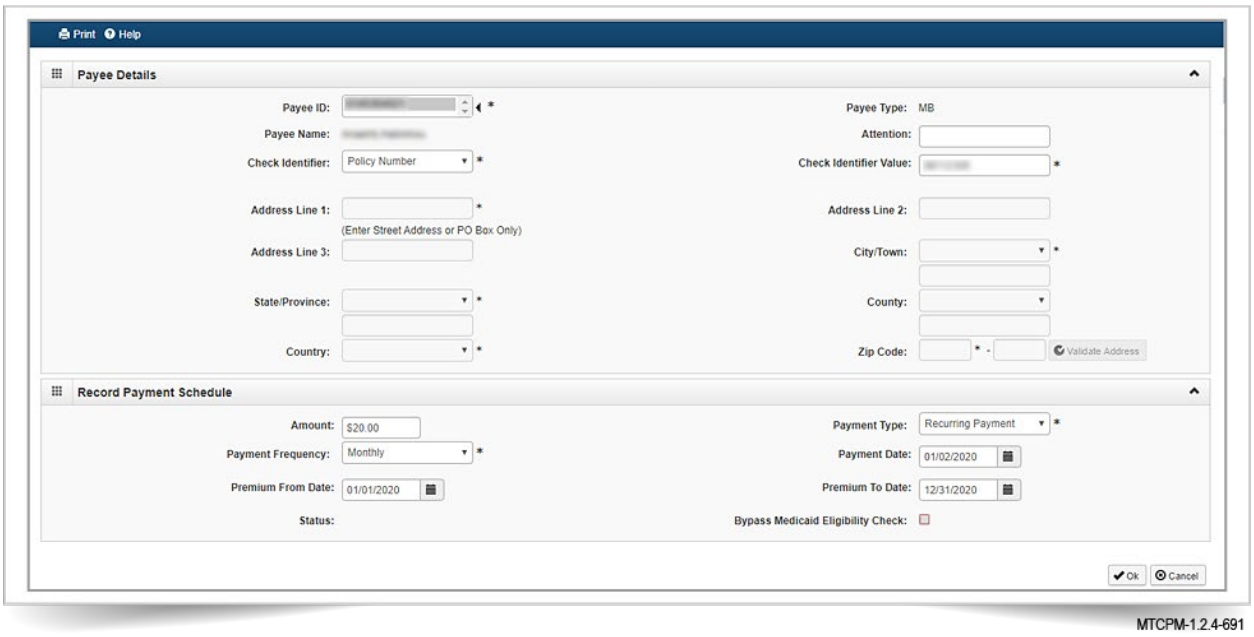


Figure 3.10.11-85. Buyout Payment screen. The Buyout Payment screen is where users can create an AP for HIPP.

PP65

The Contractor's solution shall associate all Health Insurance Premium Payment Program (HIPP) accounts payables to the Member even if the Payee is not the Member.

Team CNSI's solution for HIPP case creation and payment processing associates all HIPP APs to members even if the member is not the payee designated to receive the payment. Authorized users accomplish this by using the screen shown as Figure 3.10.11-86.

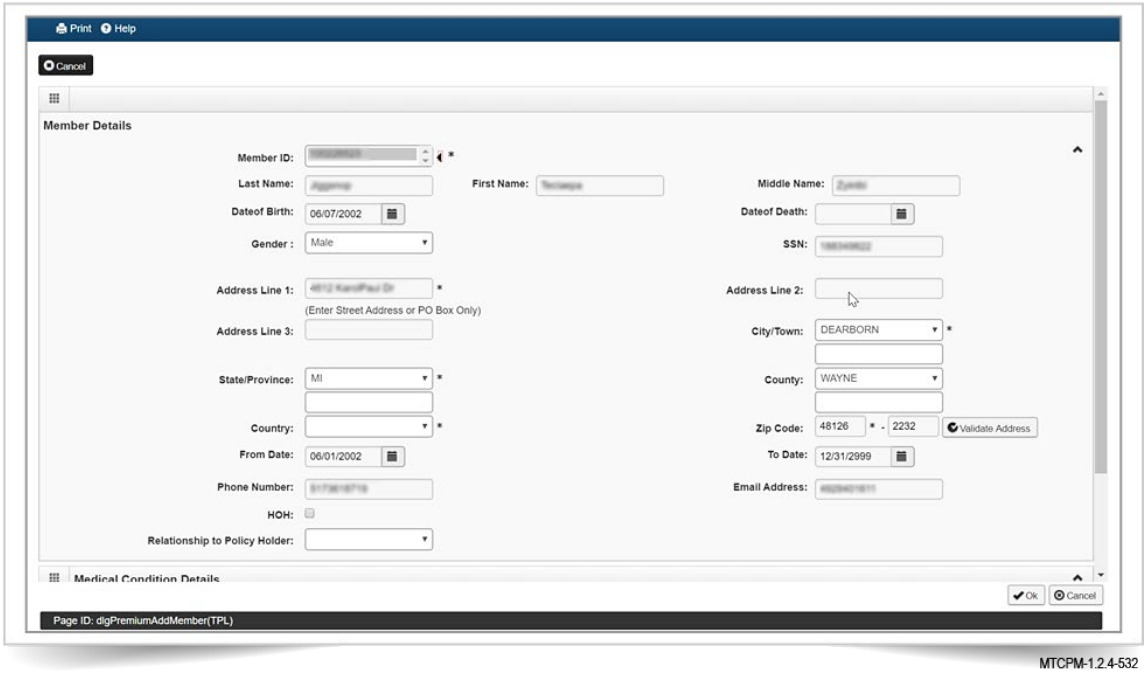


Figure 3.10.11-86. Associating HIPP to a Member. The Member Page displays a member who has been added to a HIPP case with a caption.

PP66

The Contractor's solution shall have the ability to generate separate remittance advices for transactions based on which Entity is responsible for payment as defined by the Agency.

The evoBrix X Core Claims module includes rules for grouping transactions within a RA. Groupings can be based on the entity responsible for the payment as defined in the accounting segments and per DPHHS requirements.

PP67

The Contractor's solution shall have the ability to pay prior-authorized non-emergency transportation payments in part or in total, based on configurable business rules.

Team CNSI designed the evoBrix X Core Claims module to accept prior authorized non-emergency transportation services through X12 278 transactions. Our solution enables authorized users to create and authorize non-emergency transportation services online. In addition, our solution includes pre-configured PA utilization review rules in the RuleIT platform. These rules validate the use of the units against the prior authorized tracking number submitted on the claim. Based on the utilization review, pricing rules determine payments for the submitted units either in total or in part, according to configurable business rules. Figure 3.10.11-87 and Figure 3.10.11-88 additional information.

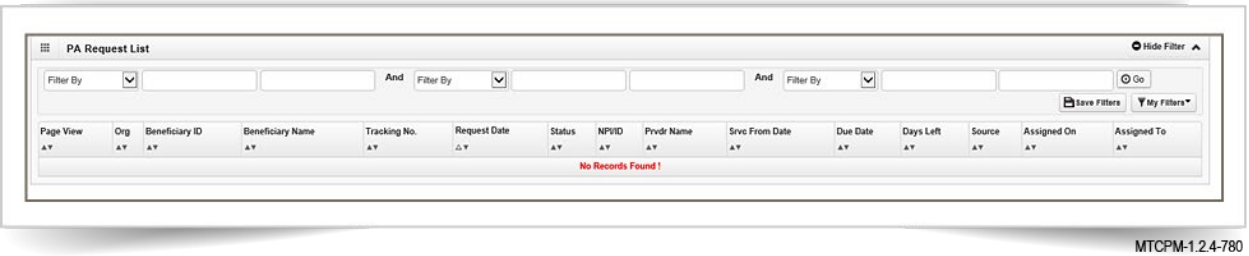


Figure 3.10.11-87. Service Authorization Request. This screen displays a service authorization for services to be performed.

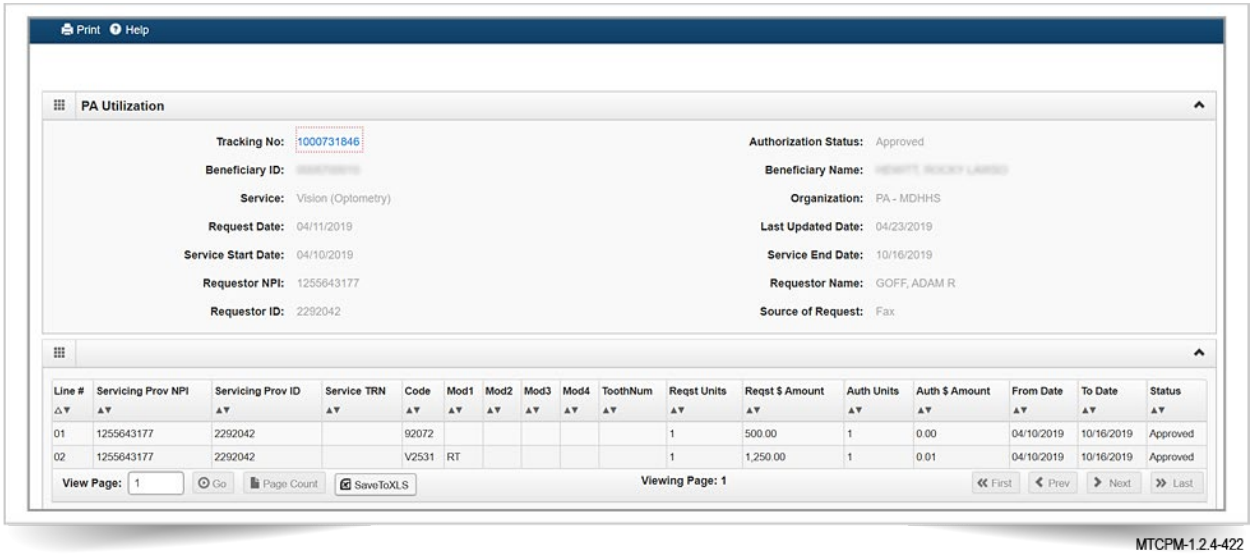


Figure 3.10.11-88. Service Authorization Utilization. Service authorizations approved for a unit and dollar amount. The evoBrix X Core Claims module tracks service authorization utilization.

PP68

The Contractor's solution shall manage the payment processes for Medicare programs (e.g., buy-in, claw back, Part D) related to Agency Healthcare Programs as defined by the Agency.

Team CNSI's solution can generate Medicare APs determined by the claw back process, buy-in program, and Part D eligibility through HIPP payment processes that define Medicare as a payee. Our solution processes these payment transactions through accounting ledgers and submits them to SAO to remit payment.

PP69

The Contractor's solution shall generate a detailed remittance advice in electronic and/or printed report format (e.g., paid claims, denied claims, reason and remark codes, error codes, payments, voids, suspensions and payment adjustments) for each Payee and/or Provider that reflects all financial activity in a payment cycle. The remittance advice will be formatted according to Agency's defined standards and language and include CMS required information (e.g., the NPI of the physician or other professional who ordered or referred the service).

The evoBrix X Core Claims module generates RAs in PDF format as well as payment transactions (i.e. X12 835) to provide complete details of all claim transactions within a pay-cycle, with information included per CMS standards. RAs are reconciled and balanced with the adjustments recouped from providers for pending ARs. The RA includes paid claims, denied claims, voided claims, adjusted claims with appropriate error codes and remarks codes, and payment adjustments resulting from recoupments. RAs are generated by each payee or provider based on DPHHS-defined business rules.

Figure 3.10.11-89 shows the RA details.

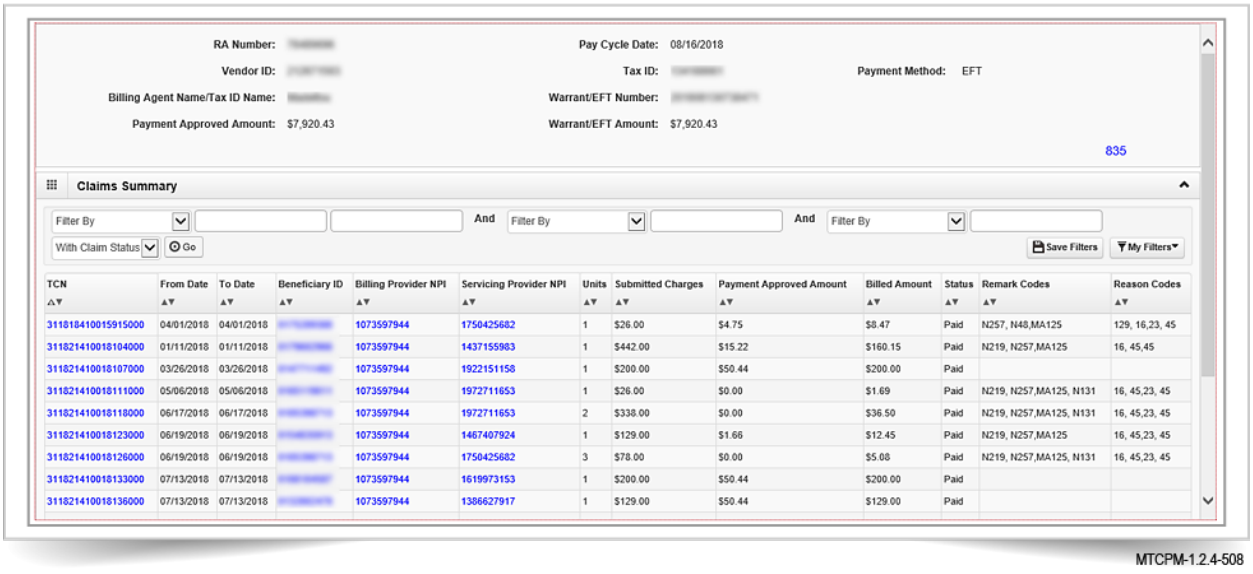


Figure 3.10.11-89. This screen depicts a sample RA that includes X12 835 details.

PP70

The Contractor's solution shall update financial transactions with payment identification details (e.g., check number, warrant number, paid date, amount paid) when the information is returned from external Entity.

The evoBrix X Core Claims module reconciles and verifies RAs and updates all claim documents with the appropriate check or EFT information received from the SAO. This information is displayed on screen and maintained with the appropriate claim documents. Figure 3.10.11-90 shows the RA details with financial transactions.

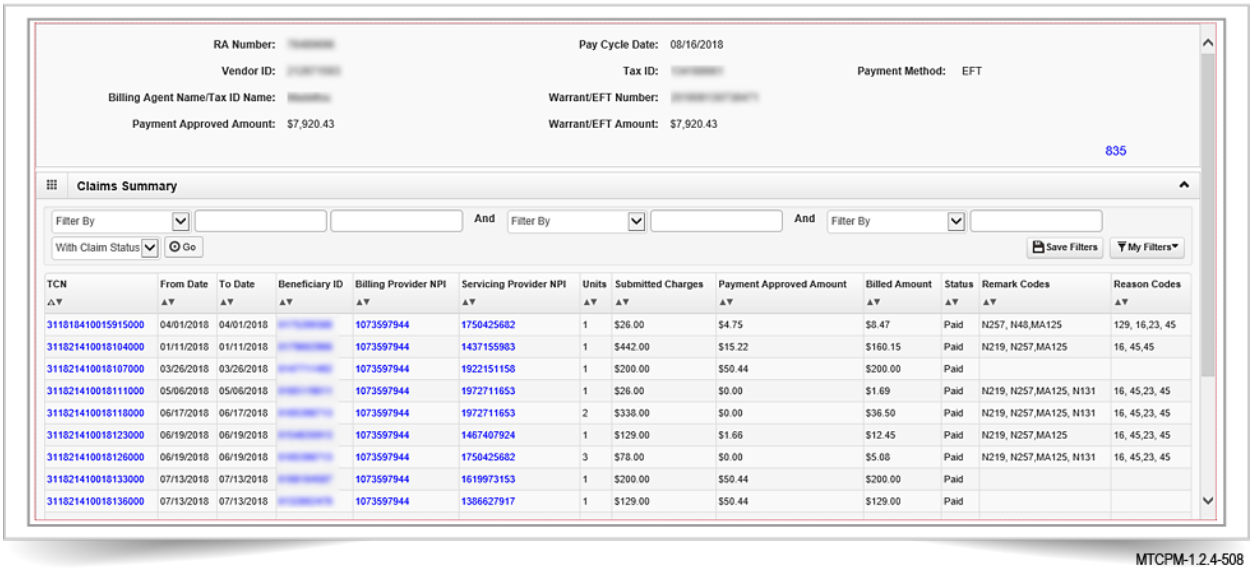


Figure 3.10.11-90. This screen depicts a sample RA that includes the check number, warrant number, paid date, and amount paid.

PP71

The Contractor's solution shall allow for Health Insurance Premium Payment Program (HIPP) payments to be created for Members or non-Members (e.g., insurance carrier, employer, policy holders), based on configurable business rules.

Team CNSI's solution includes a HIPP payment processing function that creates a HIPP /buy-out case, assigns members to a case, and assigns either member or non-members as a payee to receive the scheduled payment for a case. Payments must be approved by a financial reviewer before a payment if processed, which can be viewed online (as shown in Figure 3.10.11-91).

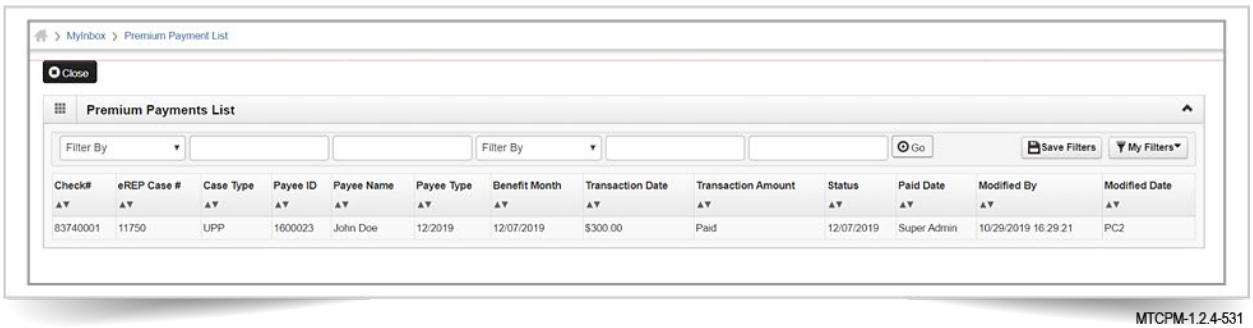


Figure 3.10.11-91. The Premium Payment List screen shows where financial reviewers assess payments.

PP72

The Contractor's solution shall capture and allow entry of additional detail in a Health Insurance Premium Payment Program (HIPP) case (e.g., policy holder name, date of birth, gender) as defined by the Agency.

Team CNSI's solution includes a HIPP payment processing function as shown in Figure 3.10.11-92. From this screen, authorized users create a HIPP/buy-out case, assign members to a case, and link a policy with policyholder and associated member detail per DPHHS requirements.

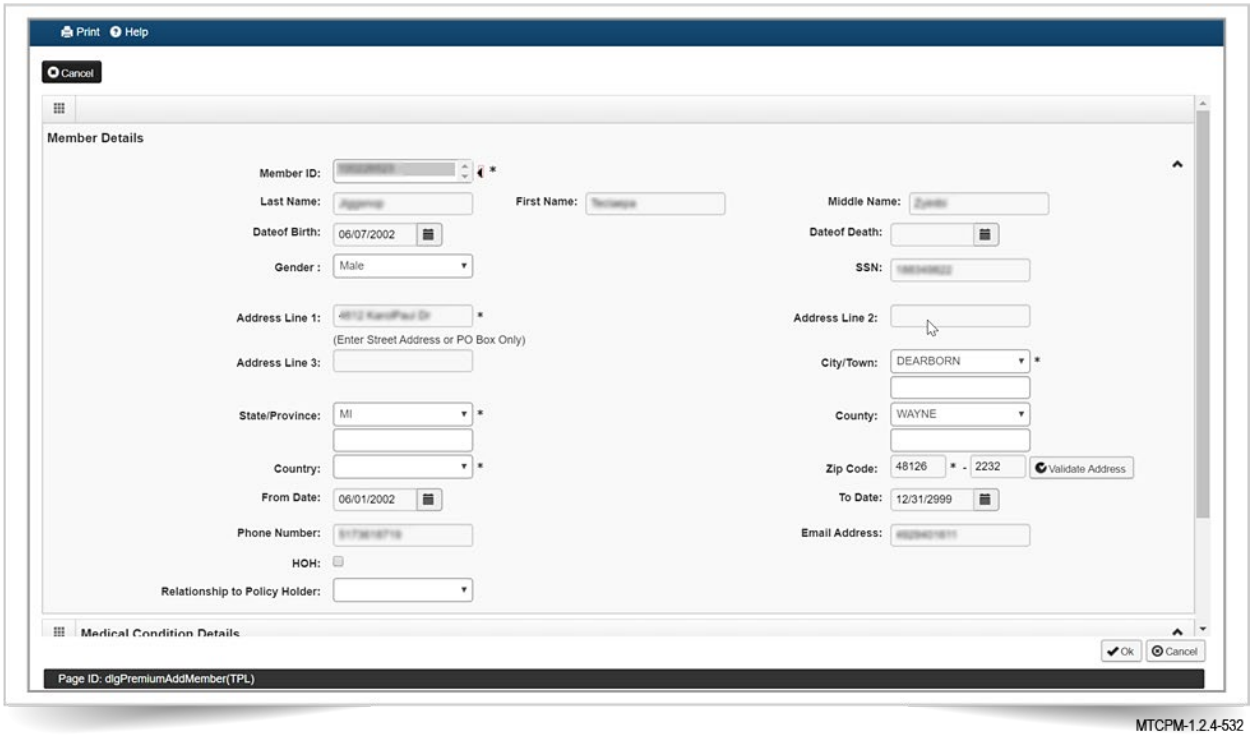


Figure 3.10.11-92. This screen shows where members are added to a HIPP case.

PP73

The Contractor's solution shall receive and allow for entry or end date of the details (e.g., diagnosis, age, gender, cost, percentage) needed to do a cost effectiveness evaluation for the Health Insurance Premium Payment Program (HIPP) as defined by the Agency.

Team CNSI's solution includes cost effectiveness calculation functionality as part of the HIPP payment process. Our solution currently does not do cost-effectiveness calculations automatically; however, it does capture and maintain members' medical conditions. The data required to process cost effectiveness calculations is captured, processed, and maintained within our solution.

PP74

The Contractor's solution shall automatically perform the cost-effectiveness calculation using information (e.g. claims history) for a redetermination and update information (e.g., premium amount) on the case for the Health Insurance Premium Payment Program (HIPP) as defined by the Agency.

Team CNSI's solution allows authorized users to perform cost effectiveness calculations using claims history and member medical condition details collected during the HIPP case creation process from the

screen shown as Figure 3.10.11-93. Our solution does not currently perform cost-effectiveness calculations automatically; users will perform the costs effectiveness calculation based on DPHHS-specific business rules using claims data and member eligibility and medical condition details.

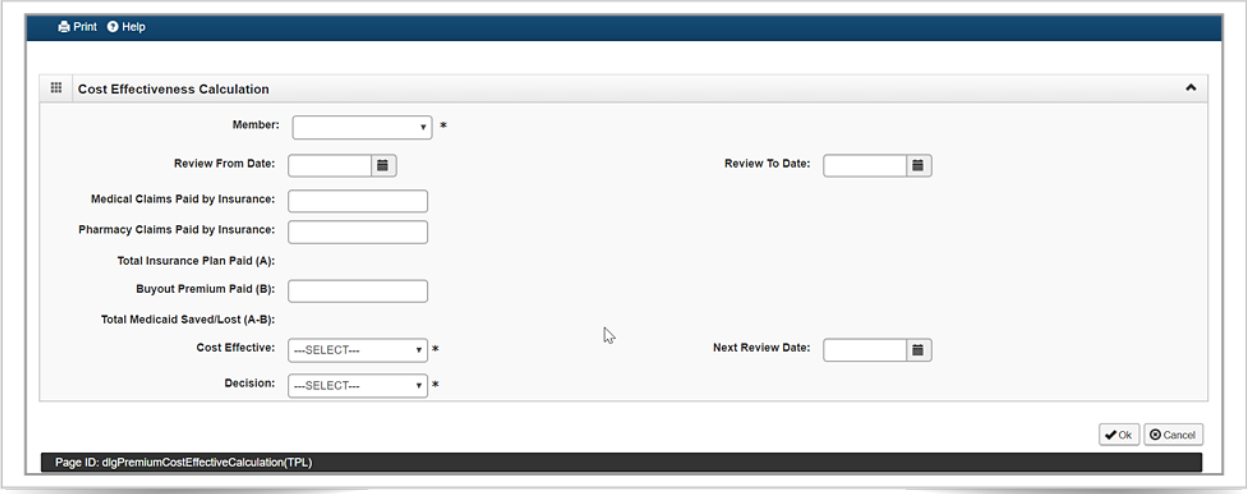


Figure 3.10.11-93. Users perform calculations during the HIPP case creation process using this cost effectiveness screen.

PP75

The Contractor's solution shall have the ability to automatically create a new HIPP case and allow for users to manually enter one as defined by the Agency.

Team CNSI's solution allows authorized users to manually create HIPP cases to link members, policies, and payees in order to process payments online. In addition, we offer an automated weekly/monthly process to identify and create HIPP cases and assign individuals for approval for third party policy coverage for those members and member conditions covered by private health coverage, per DPHHS requirements.

PP76

The Contractor's solution shall automatically assign unique case numbers on new Health Insurance Premium Payment Program (HIPP) cases as defined by the Agency.

Team CNSI's solution generates unique case numbers for each HIPP case created online per DPHHS requirements and as shown in Figure 3.10.11-94.

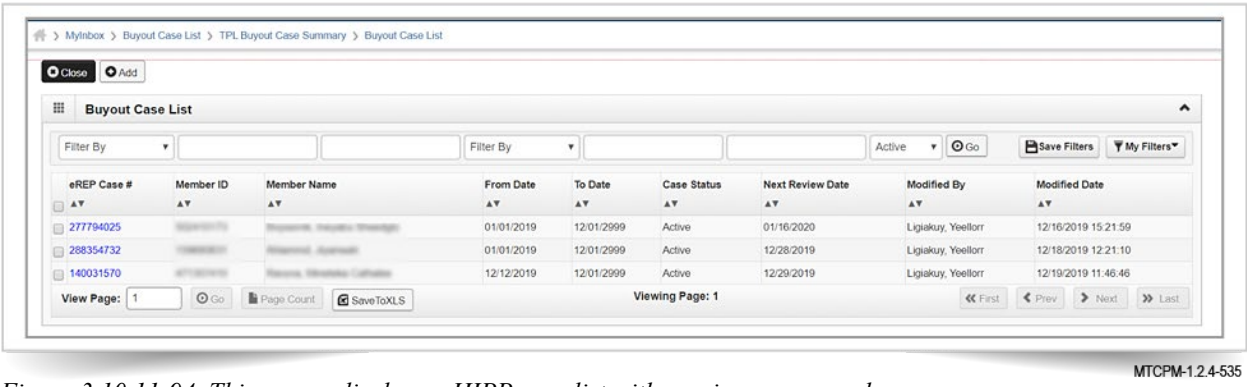


Figure 3.10.11-94. This screen displays a HIPP case list with a unique case number.

PP77

The Contractor's solution shall receive, store, maintain, display, and update detail information related to the member's third-party insurance policy (e.g. number, type, status) as defined by the Agency

Team CNSI' solution receives, stores, maintains, displays, and updates detail information related to an insurance policy (e.g. number, type, status) per DPHHS requirements. We designed our solution to include group or individual polices received through TPL leads from external sources. Authorized users then associate this information with HIPP cases using the screen shown as Figure 3.10.11-95. We maintain, store, and display TPL policies and associated information within our solution as shown in Figure 3.10.11-96.

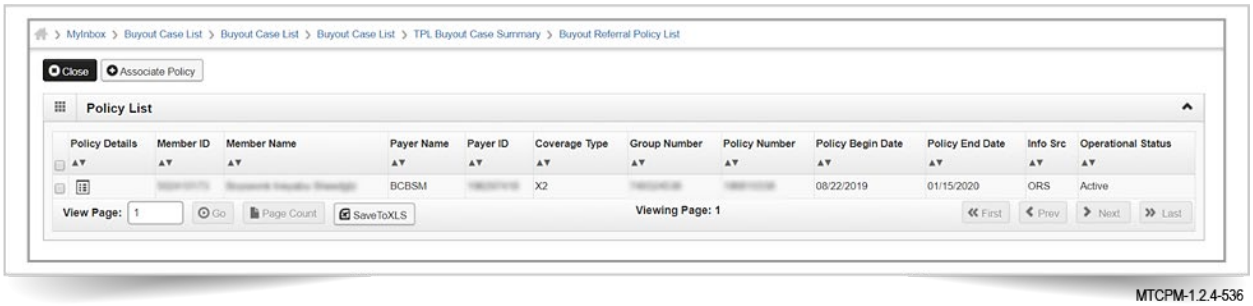


Figure 3.10.11-95. This screen displays TPL policies associated with a HIPP case.

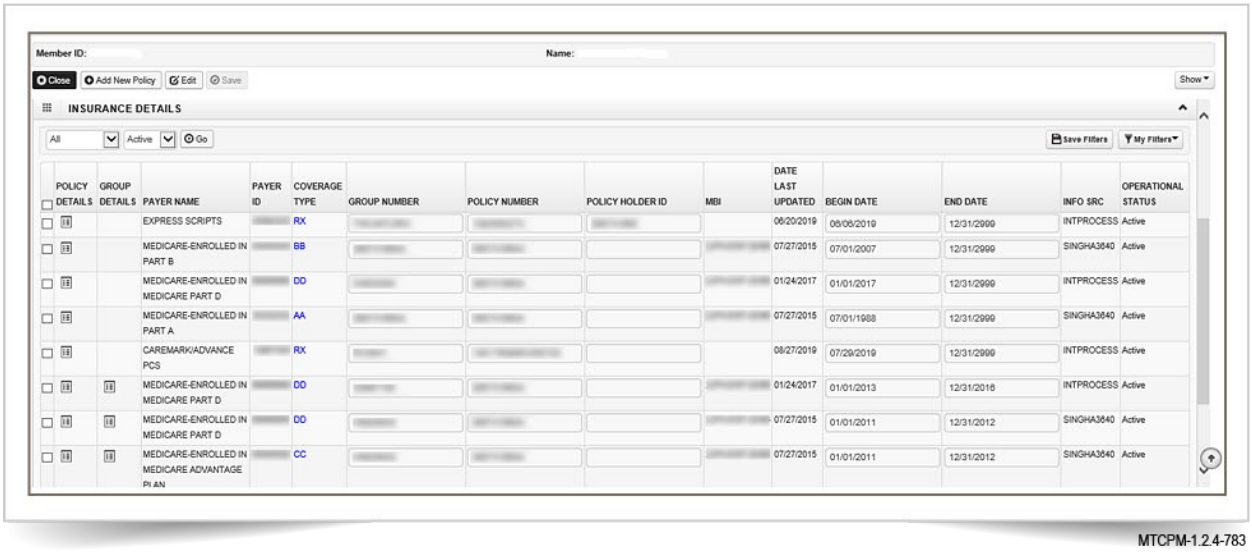


Figure 3.10.11-96. This screen displays a member's third-party insurance policy.

PP78

The Contractor's solution shall have the capability to associate a Group Policy Provider with a current Health Insurance Premium Payment Program (HIPP) case automatically and by user as defined by the Agency.

Team CNSI's solution includes the functionality to associate a group policy provider with a current HIPP case automatically and by user per DPHHS requirements. Policies can be either a group or individual policy from various lead sources.

PP79

The Contractor's solution shall allow users to trigger a recalculation of the cost-effectiveness for the Health Insurance Premium Payment Program (HIPP) Program as defined by the Agency.

Team CNSI's solution allows users to perform a re-calculation of cost effectiveness using claims history and member medical condition details collected in the HIPP case creation process. Team CNSI performs the costs effectiveness calculation based on DPHHS-specific business rules using claims data and member eligibility and medical condition details.

PP80

The Contractor's solution shall have the ability to automatically recalculate the cost-effectiveness for a HIPP case when a field used in the calculation is changed as defined by the Agency.

Team CNSI's solution can automatically re-calculate the cost effectiveness of HIPP cases based on changes to claim history data, member eligibility changes, changes to member medical conditions, and policy changes related to a case. Our solution will meet DPHHS requirements.

PP82

The Contractor's solution shall have the ability to automatically check non-emergency transportation transactions against medical claims before reimbursing, based on configurable business rules.

Team CNSI designed the evoBrix X Core Claims module to intake non-emergency transportation (NEMT) transactions as PAs through X12 278 transactions, web screens, or batch interfaces using the ISR component. Claims with PA tracking numbers are validated against pre-approved PA transactions. Claim reimbursements are determined based on PA status and utilization.

See Figure 3.10.11-97 and Figure 3.10.11-98 for additional information.

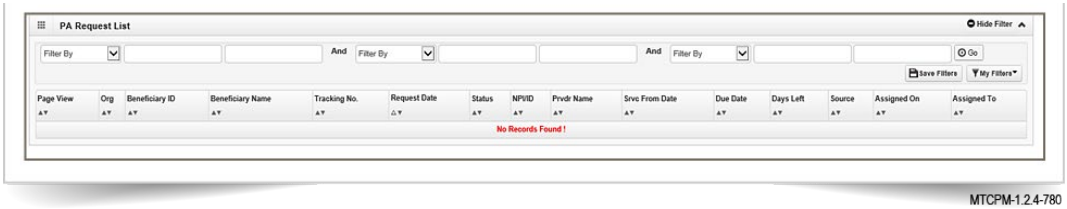


Figure 3.10.11-97. This screen depicts a service authorization for services to be performed.

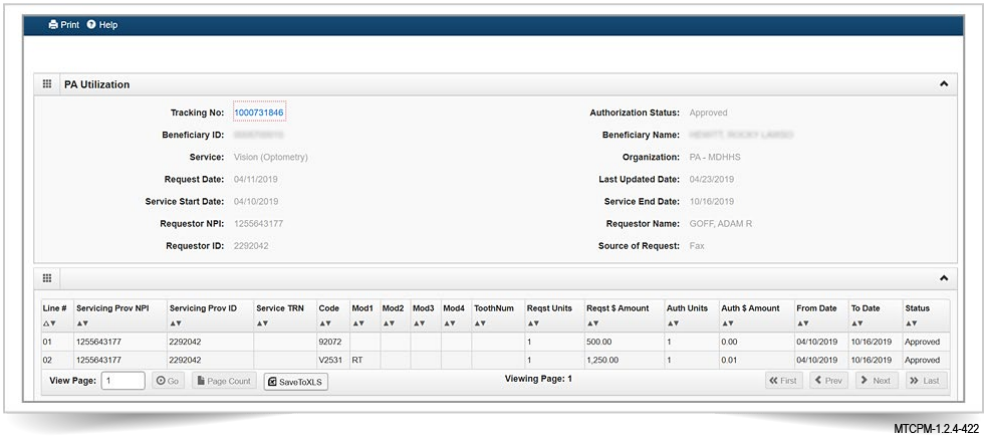


Figure 3.10.11-98. Service authorizations approved for a unit and dollar amount. The evoBrix X Core Claims module validates PA tracking numbers against pre-approved PA transactions.

PP83

The Contractor's solution shall allow for HIPP cases to have household members who are not enrolled in the HIPP program as defined by the Agency.

Team CNSI's solution allows for HIPP cases to include household members who are not enrolled in the HIPP program per DPHHS requirements. The household member and head of household information received from the eligibility system through the ISR process is stored and maintained with the member eligibility records. We revise business rules related to household members per DPHHS policies.

PP84

The Contractor's solution shall perform a reconciliation of the federal invoices for Medicare State Phase-Down contributions (also referred to as Claw back) and Medicare Buy-in payments against our member data. Invoices are corrected based on the reconciliation and submitted to Medicare as defined by the Agency.

Team CNSI's solution performs a reconciliation of the federal invoices for Medicare State Phase-Down contributions and Medicare Buy-in payments against our member data. Our solution maintains member eligibility data and identifies members for claw back and Medicare buy-in payments automatically when processing invoices and payments for Medicare as a payee. We can configure and correct invoices based on the reconciliation and submit them to Medicare per DPHHS requirements.

PP85

The Contractor's solution shall receive, store, maintain, and display Payee (e.g. HIPP) information (e.g., tax, banking, address, contact, preferred payment method) for each Payee as defined by the Agency.

Team CNSI's solution receives, stores, maintains, and displays information (e.g., tax, banking, address, contact, preferred payment method) for each payee per DPHHS requirements as shown in Figure 3.10.11-99. Cases are created to track members included in buyout or HIPP cases. Users can associate existing payees or create a new payee when the buyout case is established and processed for payments.

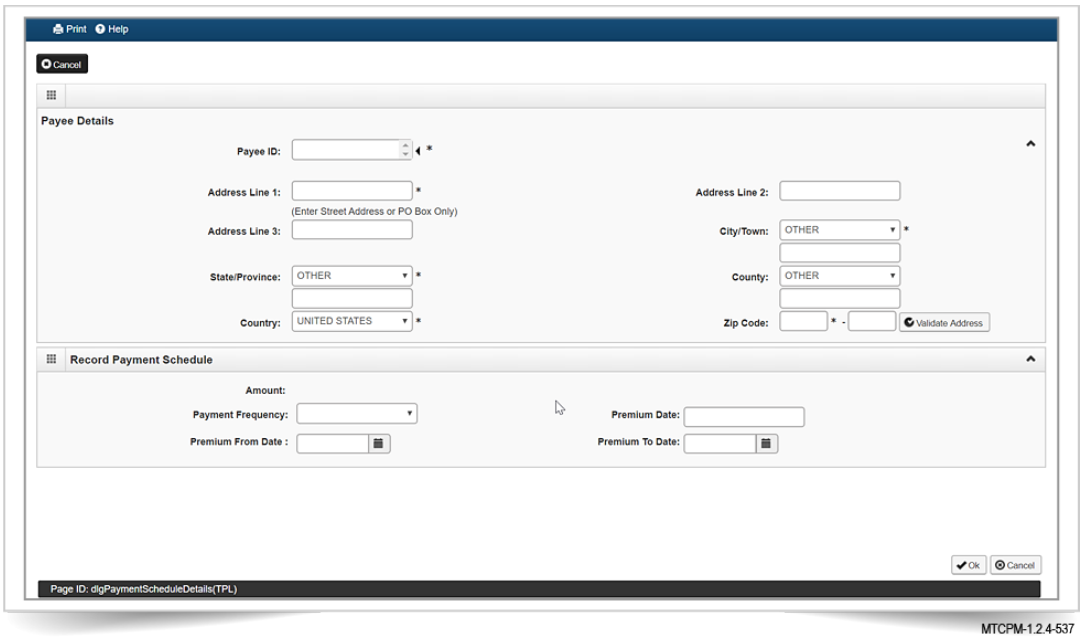


Figure 3.10.11-99. Authorized users add and track members using this screen.

PP86

The Contractor's solution shall have the ability to pay a non-Member for expenses incurred for a Member (e.g., in state or out of state transportation, HIPP) and associate the payment with the Member's record as defined by the Agency.

Team CNSI's solution includes a flexible design to handle non-member payments and track transactions to a member in HIPP cases. The solution allows non-members to be paid for expenses incurred for a member (e.g., in state or out of state transportation, HIPP) and associates the payment with the member's record per DPHHS requirements.

PP87

The Contractor's solution shall provide notes capability for all financial types (e.g., Health Insurance Premium Program (HIPP), Eligibility). The notes capability must include standard fields (e.g., date, category) and text fields as defined by the Agency.

Team CNSI's solution includes functionality for authorized users to add notes/comments to HIPP cases, as shown in Figure 3.10.11-100 and Figure 3.10.11-101. The solution maintains the history of changes and comments online for users to access. The functionality includes standard and test fields per DPHHS requirements.



Figure 3.10.11-100. Users add notes/comments at a case level to HIPP cases using this screen.

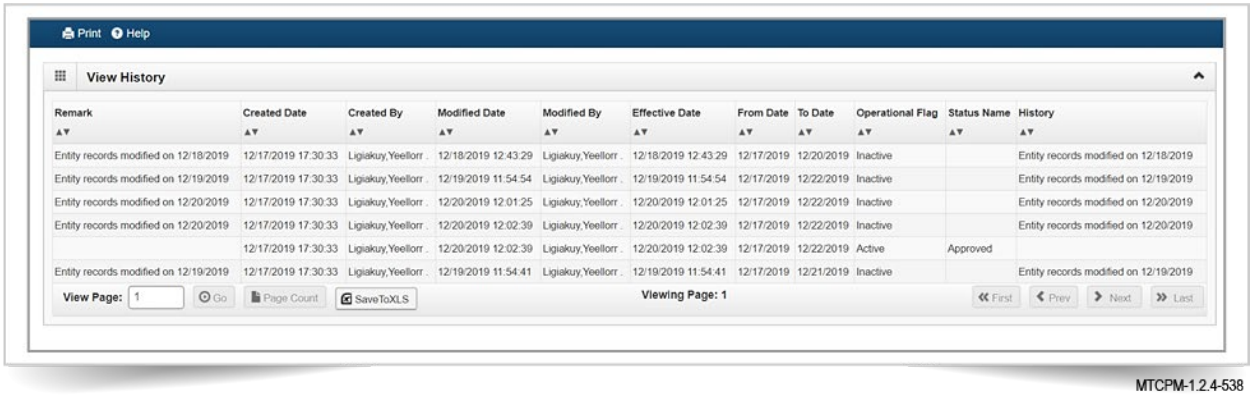


Figure 3.10.11-101. This View History screen displays modification history with comments.

PP88

The Contractor's solution shall process, track and report financial transactions related to Lump Sum payments (e.g., DSH, GME) and alert Agency staff and Payee via their preferred notification method as defined by the Agency.

Team CNSI's evoBrix X Core Claims module allows authorized users to process, track, and report financial transactions related to credit and debit gross adjustments (lump sums) through the screens shown in Figure 3.10.11-102 and Figure 3.10.11-103. DPHHS Supervisory users review the created gross adjustments and determine whether they should be approved. Approved gross adjustments are created as system-generated payment transactions and processed through payment and RA generation. DPHHS staff and payees are notified via preferred methods of RA (PDF) or X12 835 transactions and gross adjustment correspondence to notify the lump sum credit or debit transactions.

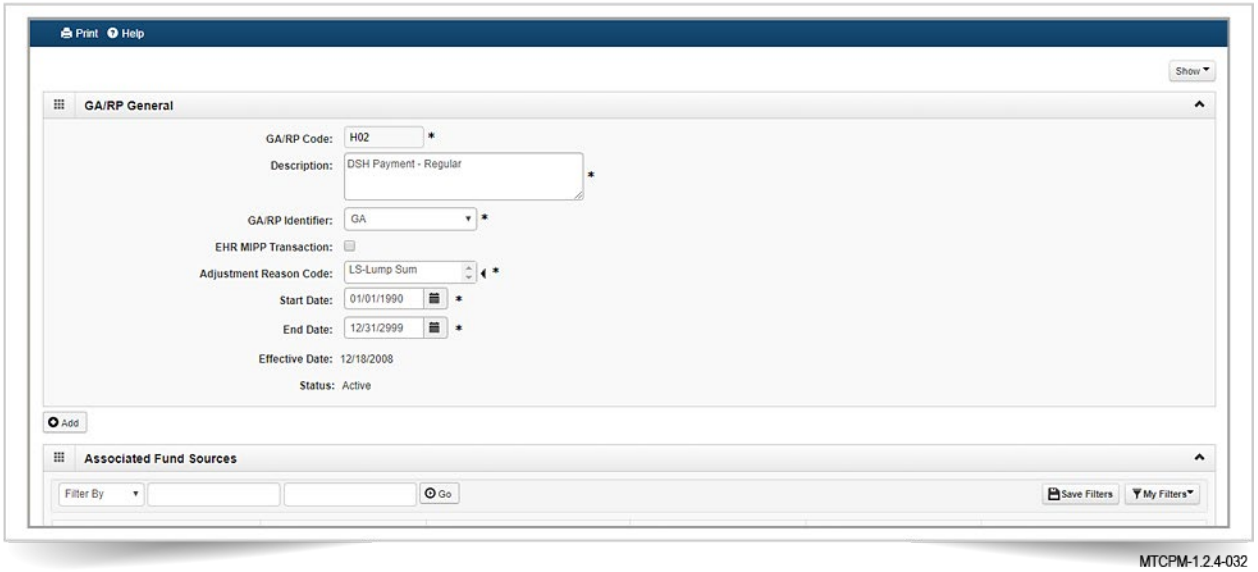


Figure 3.10.11-102. This screen shows a gross adjustment code used to fund associated sources, which is also used for tracking purposes.

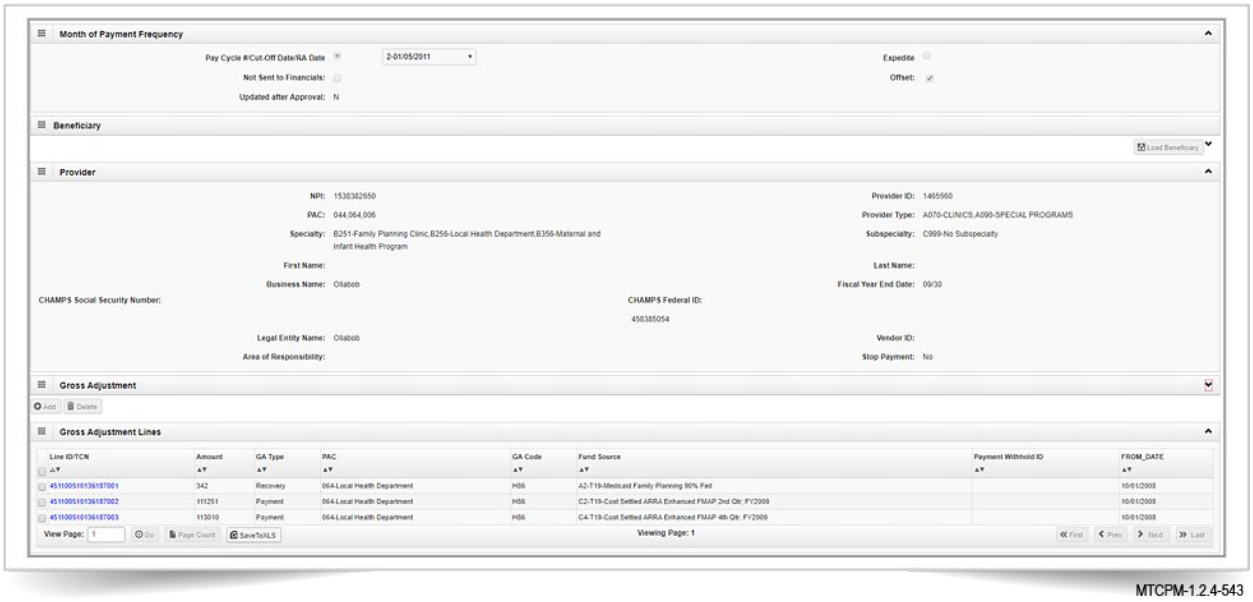


Figure 3.10.11-103. This screen displays lump sum payments generated through the gross adjustment process.

PP89

The Contractor's solution shall capture, store, and maintain current and historical participant criteria (e.g., effective dates, income, family size, etc.) to calculate and apply participant cost-sharing, including premiums and co-pays, for particular benefits based on federal and/or Agency specific criteria.

Team CNSI designed our solution to capture, store, and maintain current and historical records of participant contributions (e.g., patient pay, premium payment), household details (e.g., family members, family size, head of household) reported from eligibility and finance systems.

Team CNSI's solution provides a flexible cost sharing component that can be designed to be a fixed amount (e.g., co-pay or deductible) or a percentage of charges (e.g., co-insurance for any service). Our

solution's benefit plan definition covers cost sharing information, including premiums, co-pays, deductibles, and spend-downs. It also provides the capability to define cost-sharing frequency.

Our solution applies cost sharing during claims processing, which is assigned with a "Cost Share Met" flag at the individual and the family level. Both flags include a "Cost Share Met Date" associated for the given period, either monthly or quarterly. When the set percentage limit (e.g.: 5% of income) is met for the individual, the flag is set and recorded for the current system date. Similar rules apply for the family cost share met flag. In addition, once the family "Cost Share Met" flag is "T," our solution sets flags of all family members recorded for that system date. Team CNSI sets this up for a monthly or quarterly period.

Figure 3.10.11-104 displays this information.

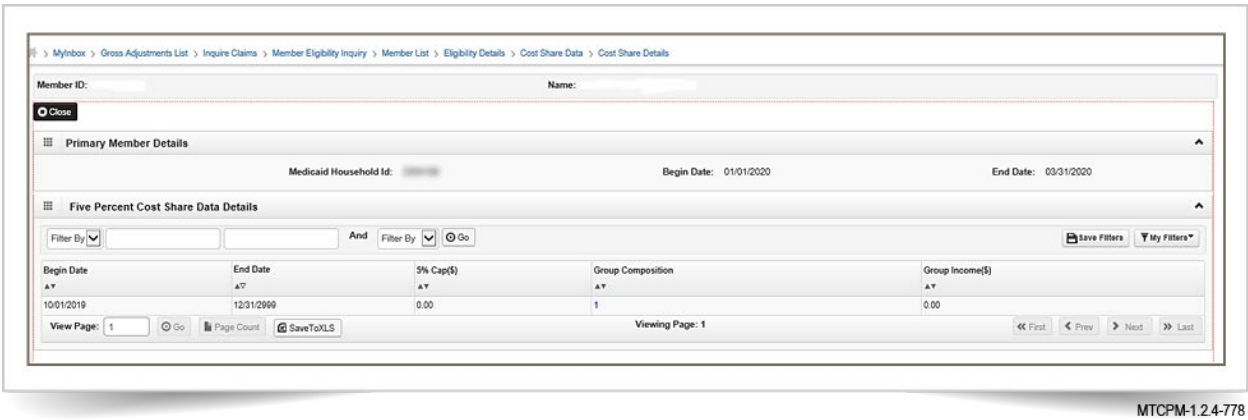


Figure 3.10.11-104. This screen shows five percent cost share details.

PP90

The Contractor's solution will generate payments and remittance advice daily (or at an interval defined by the agency).

The evoBrix X Core Claims module includes an automated process to inbound financial transactions to Financial module, process payments, and generate RAs. Our solution includes a configurable pay cycle calendar, which includes pay cycle date, payment processing date, and RA generation date. This pay cycle calendar triggers the automated process to process payments and generate RAs. In addition, we can customize our solution to trigger and generate daily payments and RAs.

Figure 3.10.11-105 shows how our solution processes lump sum payments daily.

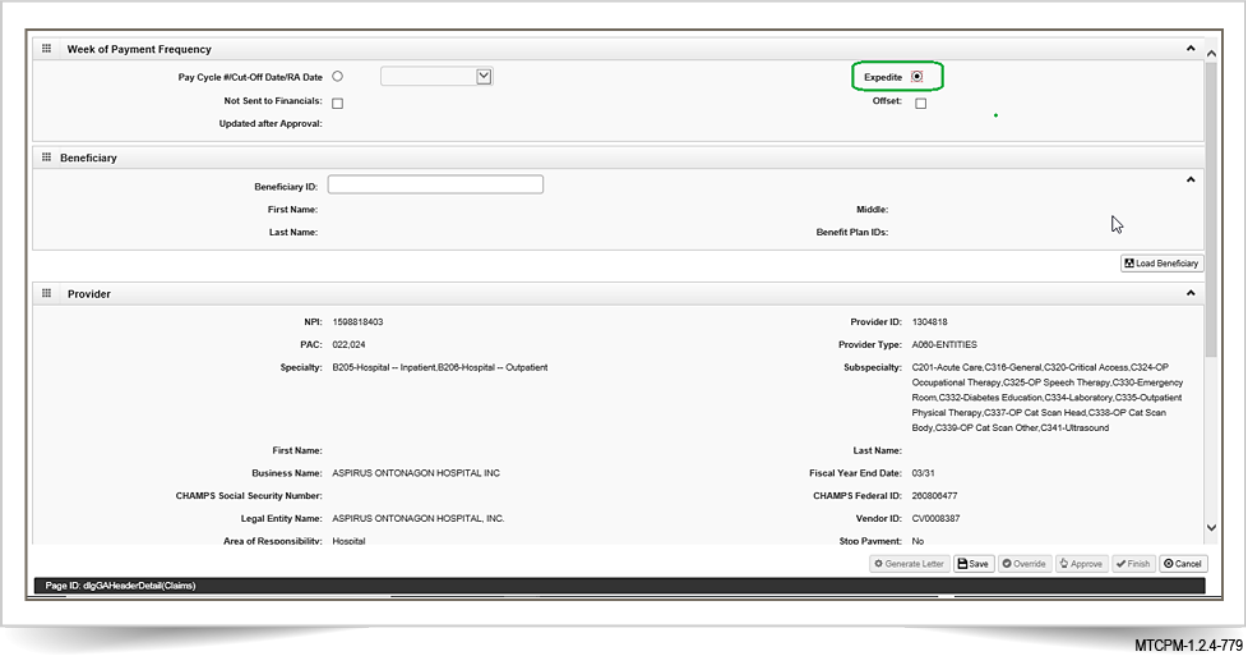


Figure 3.10.11-105. This screen displays how lump sum payments are processed daily.

3.10.12 Benefit & Reference Data Management

This section addresses requirements related to benefit and reference data management. The solution will have the capability to configure, store and manage benefit plans and support a variety of pricing methodologies, and provider contracts with the flexibility to support multiple payers and financial management processes. In support of claims adjudication, this solution will also process against service authorizations, third party insurance liability, and calculate member liabilities including cost share and cost share coordination between multiple payers. The solution will provide and maintain configurable reference data to support complex business rules utilized for claim adjudication. The Offeror must describe in detail their approach to meet each of the Benefit and Reference Data Management requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Team CNSI's evoBrix X CPMS solution provides flexible Benefits and Reference Data Management features that will enable the State to configure benefits for efficient care delivery, faster realization of program and benefit plan changes, by using the reference data received from multiple intake channels. Our solution offers a user-controlled, business rule-driven mechanism that will provide DPHHS with a flexible, out-of-the-box solution to meet most of the Agency's currently defined requirements with flexibility for supporting future program updates. Team CNSI's current CMS-certified implementations in the states of Michigan and Washington, we worked with Medicaid stakeholders to assist them with defining benefit plans to support delivery models such as Fee-for-Service, Managed Care, and Waiver programs.

The Team CNSI Advantage

Team CNSI's solution includes a proven and mature Benefit and Reference Data Management solution.

- Solution is based on CMS-certified implementations in production in Michigan and Washington
- Real-time, automated benefit plan assignments
- Highly configurable, customizable and adaptable
- Facilates state specific changes and ease of customization to embrace client's business model
- Comprehensive solution for ingestion of reference data through multiple intake channels
- Enables reference data updates via online screens

MTCPM-1.2.4-376

Team CNSI has the experience and a proven approach to efficiently and accurately configure the evoBrix X CPMS solution for Benefits and Reference data management functions to achieve the Agency's objectives. The key drivers for our approach include:

- A solution that is closely aligned with MITA principles.
- A solution that is flexible and leverages configurability.
- Decades of business operations experience gained through numerous interactions with data trading partners and online updates to reference data – handled accurately and in a timely fashion.

Our solution offers functionality beyond a traditional reference file system. It includes online functionality to identify, establish, and maintain Health Insurance Portability and Accountability Act (HIPAA) code sets and local code sets, and administer programs such as traditional, waiver, and non-Medicaid programs. Our solution also supports reference data updates via SOA-based batch processing.

Key Features of Benefits and Reference Data Management t

Supported Code Sets: As part of the claims adjudication process, our solution validates all codes that are received on a claim. The codes are checked against the national standard code sets that are preloaded into the evoBrix X Benefits and Reference Data Management solution. The evoBrix X CPMS solution also allows the Agency to load flexible and variable rate files on an on-demand basis to support the contractual agreements between the Agency and its partners. Our solution also receives feeds from CMS and other approved sources and will always maintain the latest version.

Major reference codes include:

- CPT-4 procedure codes
- Modifiers

- ICD-10 Diagnosis and procedure codes
- DRG codes
- APC codes
- Revenue codes
- HCPCS codes
- Revenue code/HCPCS relationships
- CARC and RARC codes

Reference Support for Service Authorization: Team CNSI's evoBrix X CPMS solution also allows the Agency to mandate the service authorizations by setting the service authorization flag on appropriate procedure codes. Our solution supports implementation of policy through rules-based, table-driven functionality, which enables us to flag authorized services rules for prepayment review, automates service authorization processing to reduce manual workload, provide auto-adjudication capability, and define edit disposition codes that prevent automated adjudication of a service authorization in specific circumstances. Our solution minimizes the need for software code changes, thereby increasing responsiveness to changing business needs and reducing program maintenance costs throughout operations.

Reference Support for Claims Pricing: Team CNSI's evoBrix X CPMS solution is configured to use provider-specific rates during the pricing of claims. If the rates are not available, manual prices are used for pricing the claim. The evoBrix X CPMS solution's framework not only supports the claims pricing based on the flat rates (code rates, provider specific rates, or specialty rates), but also based on procedure modifiers. The evoBrix X Integration Gateway supports the interface feeds for the rates and relative value units as well. The claims adjudication process leverages the modifiers (e.g., bilateral modifier, pre, intra, and post modifiers) submitted on the claim to price it appropriately.

Benefit Plans: Team CNSI's evoBrix X solution provides the functionality to establish, view, and maintain benefit plans. The solution offers online screen functionality to configure the benefit services through procedure codes, diagnosis codes, benefit limitations, provider exclusions, eligibility criteria, effective dates, and member cost sharing. The authorized users can leverage online screens to perform timely changes to the plan information and the solution allows the Agency to reduce or add services, define monetary limitations, or impose premium and co-pay restrictions. The solution also allows the Agency to place restrictions on Benefit Plan based on claim type, place of service, procedure code, provider type, and specialty.

Limits: evoBrix X CPMS solution supports an option to configure benefit service limits through online screens. The limit detail functionality in evoBrix X CPMS captures the necessary data to support the system's ability to edit for service limitations. Limits can be anything defined by DPHHS in units or dollars that will affect claims processing if exceeded, from the number of office visits to dental procedures to dollar maximums for a certain date range. Limits can also be associated with benefit plans, taxonomy codes, claim types, eligibility attributes, specialties, and types of treatment. Team CNSI's benefit plan cost sharing component allows a user to add or modify member premium, copayment, deductible, and out-of-pocket maximums.

Indicators related to TPL Processing: Team CNSI's evoBrix X solution is pre-configured with a wide variety of TPL edits as part of the overall repository of claims adjudication edits. The edits are configured in RuleIT, our configurable rules engine, to implement the edits, including specific claim-level attributes such as trauma indicators and ICD-10 external cause codes submitted as the primary diagnosis on the claim. As is the case with all other categories of claims adjudication edits, TPL edits are associated with exception codes that indicates the reason for edit failure.

Groups and Pricing Methodologies: evoBrix X uses a layered approach to address the claims pricing process. The approach provides flexibility and the business agility to accommodate DPHHS pricing policy changes. The evoBrix X Reference and Benefits Administration module allows the Agency to

create different groups and configure specific pricing decision matrices. The maintenance of benefit plans, limits, and rates that play a vital role during claims adjudication can be configured by the Agency using the evoBrix X application screens. The solution calculates the payment amount for each service line on the claim based on the limits and the associated groups configured in evoBrix X Reference and Benefits Administration module. The groups can further be configured to define applicable claim type, procedure, modifier, and provider type as per the program policy outlined by DPHHS. Different pricing rules can be easily configured as all of the configuration data is table-driven and allows the authorized users to quickly configure the state policies without making any major software code changes.

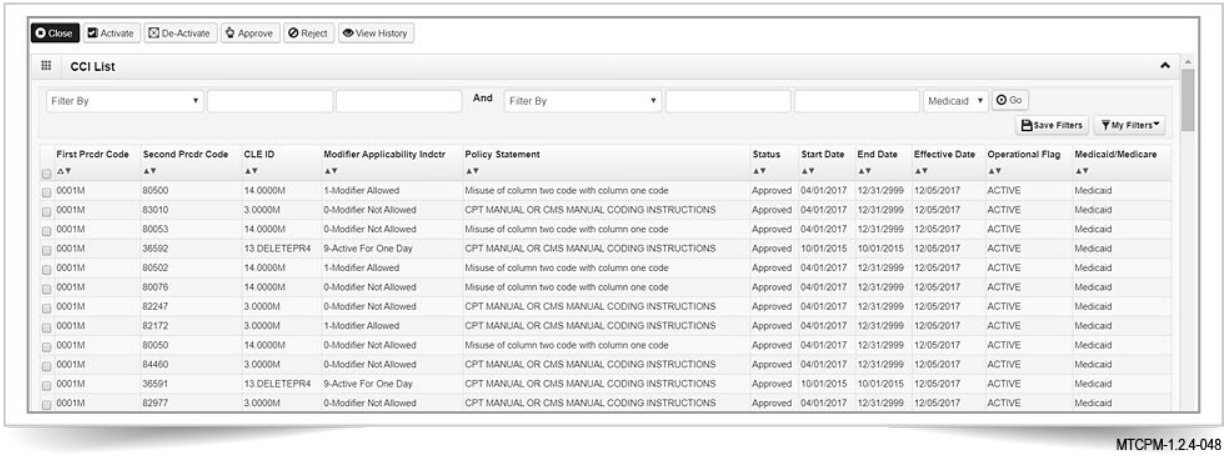
Account Codes: The evoBrix X Benefits Administration module maintains account code segment definitions, such as agency, department, fund, object, appropriation code, and federal report code etc. The system allows up to 30 account code segments. Each segment can be configured with the state-specific segment values and rules that are used to derive the account code segment values and combinations. The rules are created based on the claim derived elements, such as state or federal fiscal year, benefit plans, payer, program, claim type, and original claim payment date in case of adjustment transactions. Validation of each account code segment and the appropriate combination of segments is performed with the data configuration.

BRDM01

The Contractor's solution shall store, maintain, and utilize a list of all NCCI edits with effective and end dates, including identifying additions, changes, and deletions of codes and NCCI edits as defined by the Agency.

The evoBrix X Core Claims module includes comprehensive NCCI editing capability based on the CCI data that is configured in evoBrix X Benefits and Reference Data Management module. The NCCI information is received from CMS and regularly updated to keep the information up to date. All the data is maintained along with the begin, end and effective dates. The NCCI edits in Rules Engine will leverage the CCI data to perform the required NCCI editing.

The evoBrix X Interface Platform uses Oracle SOA for all data exchanges between the systems. The NCCI file from CMS is loaded into the system after performing all the validations based on the configuration rules defined in the interface framework. Figure 3.10.12-1 shows the NCCI edits that are maintained in evoBrix X solution.



First Prcdr Code	Second Prcdr Code	CLE ID	Modifier Applicability Indctr	Policy Statement	Status	Start Date	End Date	Effective Date	Operational Flag	Medicaid/Medicare
0001M	80500	14.0000M	1-Modifier Allowed	Misuse of column two code with column one code	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	83010	3.0000M	0-Modifier Not Allowed	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	80053	14.0000M	0-Modifier Not Allowed	Misuse of column two code with column one code	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	36592	13.DELETEPR4	9-Active For One Day	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	10/01/2015	10/01/2015	12/05/2017	ACTIVE	Medicaid
0001M	80502	14.0000M	1-Modifier Allowed	Misuse of column two code with column one code	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	80076	14.0000M	0-Modifier Not Allowed	Misuse of column two code with column one code	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	82247	3.0000M	0-Modifier Not Allowed	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	82172	3.0000M	1-Modifier Allowed	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	80050	14.0000M	0-Modifier Not Allowed	Misuse of column two code with column one code	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	84460	3.0000M	0-Modifier Not Allowed	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid
0001M	36591	13.DELETEPR4	9-Active For One Day	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	10/01/2015	10/01/2015	12/05/2017	ACTIVE	Medicaid
0001M	82977	3.0000M	0-Modifier Not Allowed	CPT MANUAL OR CMS MANUAL CODING INSTRUCTIONS	Approved	04/01/2017	12/31/2999	12/05/2017	ACTIVE	Medicaid

Figure 3.10.12-1. NCCI Information Management. Team CNSI's evoBrix X solution supports NCCI configuration through online screens.

National Correct Coding Initiative – Medically Unlikely Edits (MUE). Team CNSI's evoBrix X solution also applies MUEs to reduce inappropriate payments for claims anytime services are billed with incorrect units of service. MUEs can be based on the maximum allowable units by Revenue Code/HCPCS relationship.

BRDM02

For all historical and current code sets, the Contractor's solution shall receive, store, and maintain the crosswalk of effective and end dated code set relationships by date of service (e.g., Healthcare Common Procedure Coding System (HCPCS), Resource Based Relative Value Scale (RBRVS), All Patient Refined Diagnosis Related Grouping (APR-DRG), Outpatient Prospective Payment System (OPPS) including procedure and APC records, Medicare Severity Diagnosis Related Groups (MS-DRGs), Current Procedural Terminology (CPT), International Statistical Classification of Diseases and Related Health Problems Version 10 (ICD-10-CM (diagnosis) and ICD-10-PCS (procedure)), Diagnostic and Statistical Manual of Mental Disorders (DSM–5), Current Dental Terminology (CDT), Provider Preventable Conditions, modifiers, revenue codes, agency-specific code sets, National Council for Prescription Drug Programs, (NCPDP), National Drug Codes (NDC), Berenson-Eggers Type of Service (BETOS), and MDC (Major Diagnostic Categories)) as defined by the Agency.

evoBrix X Benefits and Reference Data Management solution accepts data sets from CMS and other approved sources for all types of code sets, custom loads and variable rates to support the contractual agreements between the State and other MPATH partners. Code sets can be updated using either UI screens or interfaces. Both methods allow the changes to be either auto approved or hold for approval through a workflow process, which can be defined as per DPHHS requirements. The workflow process requires personnel with elevated privilege to review and approve/reject the changes to a code set.

Team CNSI will make changes to reference code sets, with appropriate testing and validation, only upon receiving authorization from DPHHS or upon mandates from CMS. Our solution also supports reference data ingestion from multiple channels and tracks reference information changes related to payment methodology. Based on the agreed-upon methods and schedules, Team CNSI will set up our evoBrix X solution to update the reference data periodically. Figure 3.10.12-2 illustrates the Diagnosis Codes maintained in the evoBrix X system.

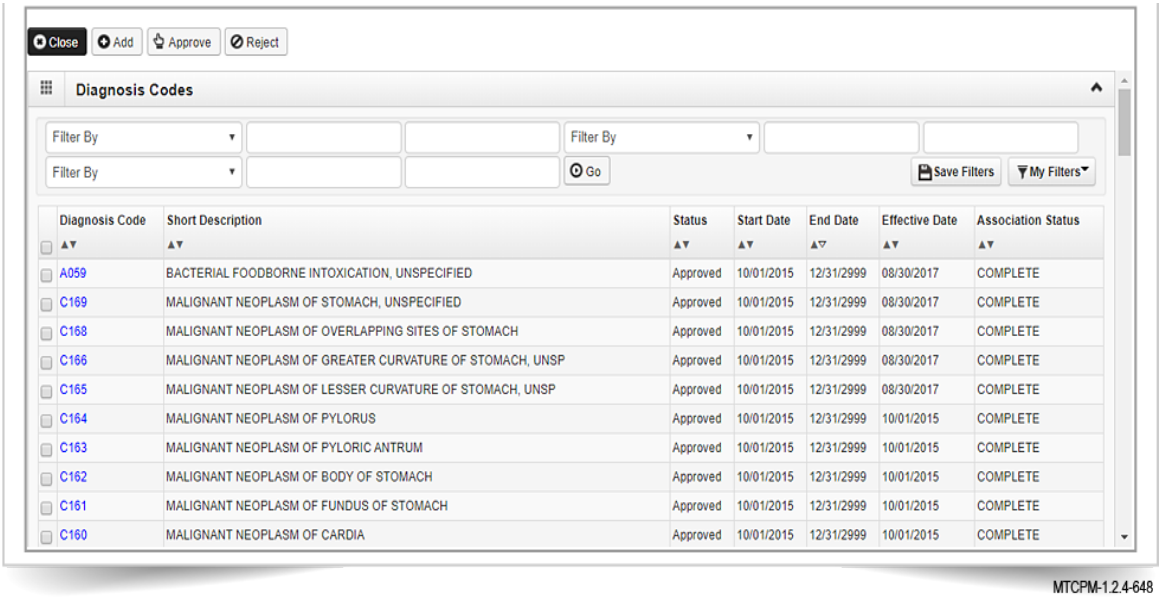


Figure 3.10.12-2. Diagnosis Code sets. Team CNSI's evoBrix X solution stores codes set with effective date and end date.

Team CNSI's evoBrix X CPMS solution ensures that all reference codes are pre-loaded into the evoBrix X Benefits and Reference Data Management area and checked against the National Standard code sets. The historical information for each code set is maintained with an effective date and end-date. Some of the major reference codes in the system include CPT-4 procedure codes, Modifiers, ICD-10 diagnosis (ICD-10-CM) and procedure (ICD-10-PCS) codes, DRG codes, APC codes, Revenue Codes, HCPCS codes, Revenue Code/HCPCS relationships, Resource Based Relative Value Scale (RBRVS), OPPS-based rates; NDC codes. System will be customized to accept BETOS and MDC code sets.

Figure 3.10.12-3 shows the overall code sets and menus used to access each type of data set.

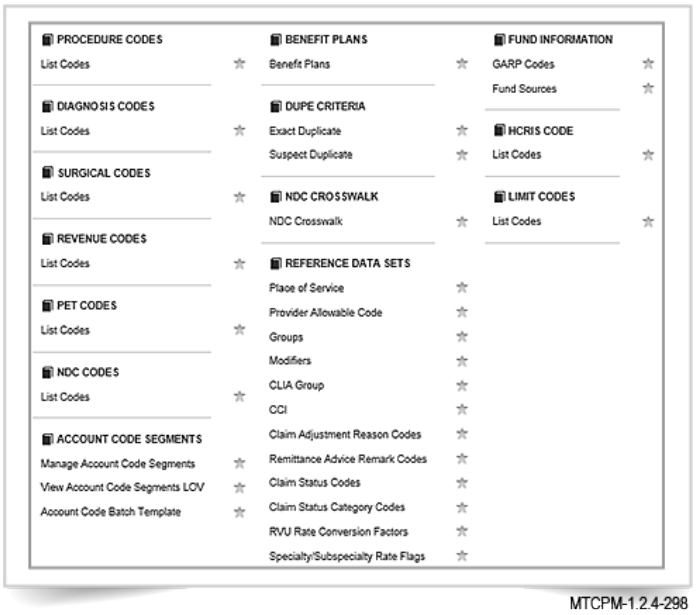


Figure 3.10.12-3. Management of Reference Files. Our evoBrix X solution can store and maintaining different codes and reference file data.

BRDM03

The Contractor's solution shall capture, store, maintain, and display a crosswalk of provider characteristics (e.g., type, specialty, taxonomies, accreditations, and certifications) against all code sets using Agency defined configurable business rules.

evoBrix X Benefits and Reference Data Management solution maintains all industry standard taxonomies which are mapped to provider types, specialties and sub specialties. The system allows to map the provider types and specialties supported by the State under different administrations/programs. Any State specific requirements and rules such as credentials, licensing, accreditations, and certifications for a Provider Type, Specialty and Subspecialty combination can be configured. Our solution uses Provider Allowable Codes (PAC) to associate standard and non-standard taxonomies through a comprehensive Permission Matrix.

The evoBrix X system is capable of cross walking provider characteristics against procedure and revenue code sets and has the capabilities to easily configure any new business rules defined by DPHHS (see Figure 3.10.12-4).

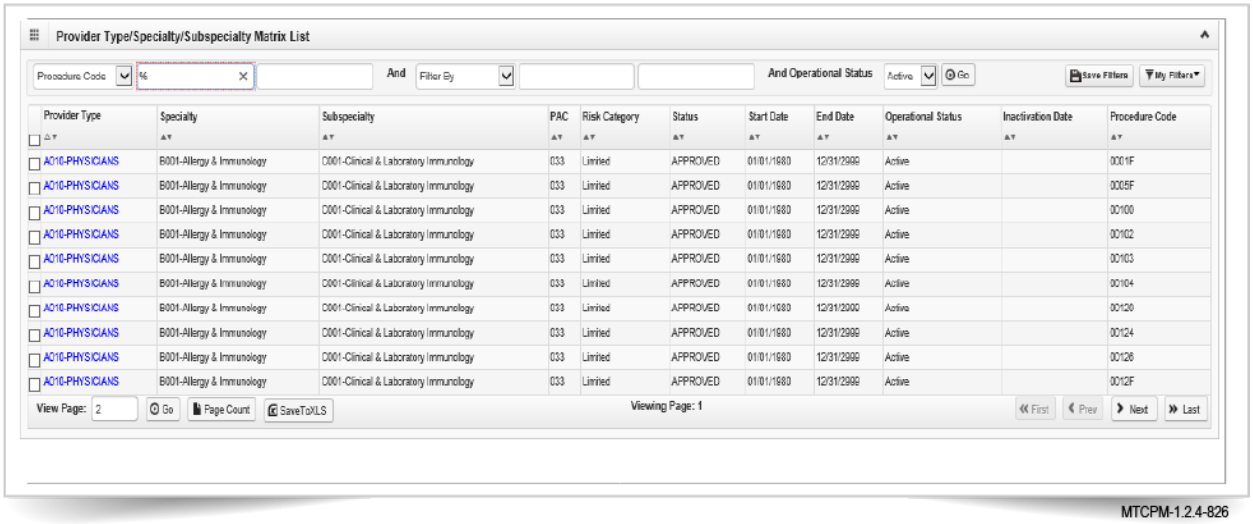


Figure 3.10.12-4. evoBrix X Enables Crosswalk of Provider Characteristics, Procedure and Revenue Code Sets. This crosswalk matrix is easily configured per DPHHS business rules.

BRDM04

The Contractor shall have the capability to create, maintain and manage multiple eligibility group valid values as defined by the Agency.

Team CNSI's evoBrix X solution provides the ability to configure, define and maintain various eligibility parameters such as Scope, Coverage, Program, Recipient Aid category (RAC) and Type of Assistance (TOA), Eligibility Aid Category (EAC), Category of Assistance (COA). These parameters help to categorize members under defined eligibility groups like Mandatory categorically needy group (or) Optional categorically needy group (or) Medically needy group as such, and further subdivide members based on Low Income families, Poverty Level-related members, ABAD(Aged, Blind and Disabled), Supplemental Security Income (SSI) recipients, Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI) categories. These defined eligibility group along with other member attributes enable DPHHS staff to tailor benefit plans with appropriate covered services.

BRDM05

The Contractor's solution shall store and maintain reference files for all reimbursement methodologies as defined by the Agency to include but not limited to the following: (e.g.,

a) provider contracted rates

b) CPT/HCPS/CDT and modifier codes

c) fee schedule for the corresponding date

d) RBRVS claims

e) Manual pricing

f) Place of service

g) Specialty type

h) Pay by report

i) Age range

j) Category of service

k) CDT procedure code fee schedule

l) Revenue codes

m) APR-DRG (Diagnosis-Related Group)

n) APG

o) Per Diem at provider specific rates

p) Add-on pricing amounts to any pricing structures based on other claim attributes (e.g. service facility, provider type/specialty, place of service etc.)

q) Provider specific encounter rate

r) Variable percentage of billed charge

s) Variable percentage based on provider type (FQHC, RHC, IHSp)

t) PMPM with line level detail

u) Medicare's Outpatient Prospective Payment System

v) Bundled/unbundled pricing

w) Global service pricing

x) Calculation required for resource-based relative value system fee schedule for radiology, anesthesia, and general medical services

y) Tiered pricing into which a variety of services are grouped depending on the treatment type and intensity of care required

z) Invoicing pricing (e.g., plus/minus percentage, procedure code)

aa) Geographic designation

bb) Lab pricing

cc) Special pricing based on time (e.g. anesthesia)

dd) Medicare crossover claims

ee) Cost to charge percentage

ff) Maximum of inpatient charges)

gg) Radiology codes with multiple components

Team CNSI's evoBrix X Benefits and Reference Data Management solution has multiple intake channels for ingesting reference data to facilitate MPATH business and system operations users. Team CNSI's evoBrix X CPMS solution ensures that all reference codes are pre-loaded into evoBrix X Benefits and Reference Data Management module and checked against the National and Federal Standard code sets. Some of the major reference codes in the system include CPT-4 procedure codes, modifiers, ICD10 diagnosis and procedure codes, DRG codes, APC codes, Revenue Codes, HCPCS codes, Revenue Code/HCPCS relationships, OPPS-based rates and procedure code relationships/MUE limits per the National Correct Coding Initiative (NCCI). Some of the high-level features of the solution are highlighted in Figure 3.10.12-5 below.

Feature	Description
Professional Claims – (priced at the service line level) a) provider contracted rates b) CPT/HCPS/CDT and modifier codes c) fee schedule for the corresponding date	Team CNSI's evoBrix X CPMS solution uses indicators on the billing provider record and the provider contracted rates to price Professional Claims per the fee schedule. The Core Claims module supports modifier pricing, which can occur either by a code to the modifier entry in the reference file or through charge mode rates. It allows modifier pricing based on both a percentage of the fee schedule and on an additional rate applied based on the charge mode rate.
d) RBRVS claims x) Calculation required for resource-based relative value system fee schedule for radiology, anesthesia, and general medical services bb) Lab pricing cc) Special pricing based on time (e.g. anesthesia)	Team CNSI's evoBrix X CPMS solution is configured to price claims for radiology, anesthesia and general medical services based on resource-based relative value system fee schedule. The system accommodates any annual updates to the Practitioner Fee Schedule based on CMS-released RBRVS, lab services' fee schedules and any additional state-specific Medicaid fee schedules.
e) Manual pricing	Team CNSI's evoBrix X CPMS solution suspends claims for manual pricing based on the "Manual Price" indicator on service codes. When no pricing fee schedules are available, the adjudication process posts an edit for manual pricing based on DPHHS business rules.
f) Place of service g) Specialty type i) Age range j) Category of service	Team CNSI's evoBrix X CPMS solution provides the capability to maintain benefit plans, limits, and rates using the application screens. Benefit plan setup screens allow authorized users to define the parameters using the restrictions feature. Place of service, Specialty Type, Age range can be configured as restriction parameters. The system allows to add category of service using procedure codes, diagnosis codes, benefit limitations, provider exclusions, eligibility criteria, effective dates and member cost sharing.
h) Pay by report	Team CNSI's evoBrix X CPMS solution can be set up to remove the duplicate member records on the PMPM payment report. The business rules to identify potential duplicate data conflicts are configurable. Based on the Agency's policies and rules, appropriate action can be set up to ensure that only unique members are considered for the additional PMPM case management fee payment.
k) CDT procedure code fee schedule	The evoBrix X CPMS solution uses indicators on the billing provider enrollment record and contracted rates with the providers to price dental claims per the current dental terminology (CDT) fee schedule. Fee schedule pricing logic contains rules that retrieve provider contracted rates and procedure code rates from the evoBrix X Benefits and Reference Data Management module.
l) Revenue codes m) APR-DRG (Diagnosis-Related Group) n) APG o) Per Diem at provider specific rates	Team CNSI's evoBrix X CPMS solution is pre-configured to leverage APR-DRG 3M grouper for Inpatient pricing. The pricing methods will leverage data elements defined below to calculate the final inpatient paid amount at a header level using DRG rate factors (e.g., DRG code, Relative Weight, Length of stay), Provider DRG factors (e.g., DRG base rate, operating ratio, skilled days, discharge rate) and Provider rates (Revenue codes for room and board). The system is also configured to price claims on the per diem rate on provider contracts instead of routing the claim to the DRG grouper for those providers without DRG assignment. This includes providers such as nursing facilities, hospice, psychiatric residential treatment facilities and rehabilitation hospitals. Our solution also supports pricing of long-term care claims and hospice claims based on room and board charges and other services. All this information is used to price the claims.
p) Add-on pricing amounts to any	Team CNSI's evoBrix X CPMS solution enhances or decreases the

Feature	Description
pricing structures based on other claim attributes (e.g. service facility, provider type/specialty, place of service etc.)	payment amount based on defined parameters in add-on pricing. Our solution handles bundling and unbundling of services and is supported by NCCI limits editing.
q) Provider specific encounter rate r) Variable percentage of billed charge s) Variable percentage based on provider type (FQHC, RHC, IHSp)	Team CNSI's evoBrix X CPMS solution is configured to price claims at provider-specific rates, such as the encounter rate established using the clinic's current prospective payment system (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) or the Indian Health Service all-inclusive rate (AIR) methodology for Tribal Health Centers (THC). The encounter rate will be processed based on the encounter revenue code and detail line item combination, with the payment being posted on the encounter service line. The pricing logic includes the flexibility to validate the number of encounters received in a day from the provider for the same member along with the diagnosis.
u) Medicare's Outpatient Prospective Payment System	Team CNSI's evoBrix X CPMS solution prices outpatient claims at the service line level. Claims are identified for Outpatient Prospective Payment System (OPPS) pricing using claim type and provider indicators and the Revenue Fee Schedule. The solution leverages OPPS and Ambulatory Payment Classifications (APC)-related editing and pricing using HSS APC software for outpatient claims. This includes services rendered in Hospital outpatient departments, Ambulatory Surgery Centers and Outpatient therapy providers such as Comprehensive Outpatient Rehabilitation Facilities. Quarterly updates published by Medicare related to OPPS/APC methodology, pricing, and editing are maintained and used appropriately.
t) PMPM with line level detail	Team CNSI's evoBrix X CPMS solution has capability to generate PMPM payments with both header and line level details using configurable service sources.
v) Bundled/unbundled pricing w) Global service pricing	Team CNSI's evoBrix X CPMS solution provides the capability to configure the edits that are bundled in evoBrix X RuleIT engine. Our solution is currently defined bundling edits for lab services. The system is capable to define additional bundling of edits per Agency requirements using UI screens. The evoBrix X Core Claims module includes standard pricing methodology rules to handle global services, i.e., surgical pricing. Surgical pricing (e.g., bariatric surgery, surgical services, surgery, pre- and post-op, prenatal) applies a Relative Value Unit (RVU) configuration to determine the appropriate rate adjustment to be applied on the base rate of primary procedure code. Surgical pricing rules determine the primary procedure and other procedures based on National Correct Coding Initiative (NCCI) editing and bundled services.
y) Tiered pricing into which a variety of services are grouped depending on the treatment type and intensity of care required	Team CNSI's evoBrix X CPMS solution will be configured to price and process claims using the Level of Care/Tiered Pricing method. The system provided the capability where authorized users can configure the business rules based on treatment type and intensity of care required.
z) Invoicing pricing (e.g., plus/minus percentage, procedure code)	Team CNSI's evoBrix X CPMS solution performs COB pricing when relevant data is received in a claim transaction. This includes the logic to compute the Medicaid payment amount to be the lower of Medicare patient responsibility amount or the difference between the Medicare payment and the allowed Medicaid payment amount.
aa) Geographic designation	Team CNSI's evoBrix X CPMS solution has the capability to support rates based on postal codes.
dd) Medicare crossover claims	Team CNSI's evoBrix X solution supports receipt and processing of

Feature	Description
	Medicare crossover claims. Special rules are configured in evoBrix X RuleIT engine for the processing of these claims. This includes the logic to compute the Medicaid payment amount to be the lower of Medicare patient responsibility amount or the difference between the Medicare payment and the allowed Medicaid payment amount.
ee) Cost to charge percentage	Team CNSI's evoBrix X CPMS solution has the capability to store and maintain Cost to charge percentages.
ff) Maximum of inpatient charges)	Team CNSI's evoBrix X CPMS solution is preconfigured to check for cost share limits for the individual and family during claim adjudication. Benefit plan cost sharing allows a user to add or modify member premium, copayment, deductible, coinsurance and out-of-pocket maximums. A "Cost Share Met" flag is maintained in the system at the individual and family level. The "Cost Share Met" flag will be reset every quarter/month based on State policy.
gg) Radiology codes with multiple components	Team CNSI's evoBrix X CPMS solution has the capability to store and maintain radiology codes with multiple components for pricing the claim.

Figure 3.10.12-5. evoBrix X Reference Files. evoBrix X supports a wide range of reference files that cover all of the required methodologies.

Figure 3.10.12-6

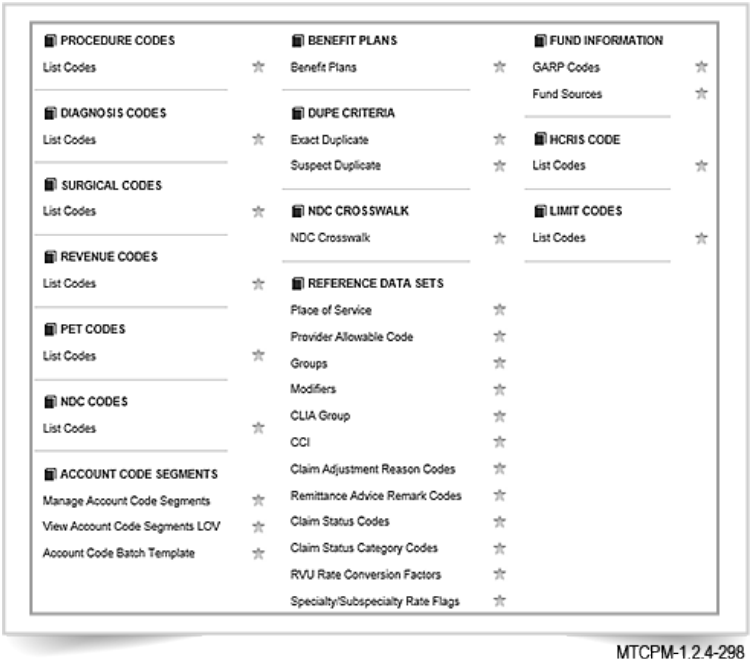


Figure 3.10.12-6. Management of Reference Files. Our evoBrix X solution is capable of storing and maintaining different codes and reference file data.

Figure 3.10.12-7

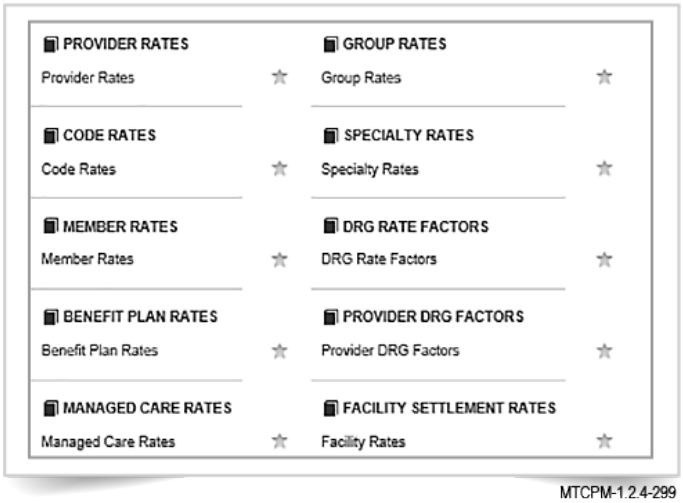


Figure 3.10.12-7. Management of Rate Data. Our evoBrix X solution can store and maintaining different rate types.

Below is the high-level reference how data is used in the evoBrix X Core Claims module for reimbursement methodologies with different claim types.

- **Professional Claims:** The evoBrix X Core Claims module utilizes contracted rates with the providers to price professional claims per the fee schedule. The system is configured to utilize the rates for practitioners, medical suppliers, and other professionals as established by the Agency. Our solution supports pricing by multiple fee schedules for professionals, including resource-based relative value system for radiology, anesthesia, and general medical services. It accommodates any annual updates to the Practitioner Fee Schedule based on CMS released Resource Based Relative Value Scale (RBRVS), ambulance services, lab services fee schedules, and any additional state-specific Medicaid fee adjustments.

  Fee schedule pricing logic contains rules that retrieve provider contracted rates and CPT4/HCPCS procedure code rates. A combination of procedure codes and modifiers is used to derive the fee schedule rate. The Core Claims module supports modifier pricing, which can occur either by a code to the modifier entry in the reference file or through charge mode rates. It allows modifier pricing based on both a percentage of the fee schedule and on an additional rate applied based on the charge mode rate. Our solution has the capability to execute pricing rules set in predefined configurable sequences when multiple sets of rules apply to a single service line. Manual pricing will be performed when no fee schedules are available.

- **Dental Claims:** The evoBrix X Core Claims module uses indicators on the billing provider enrollment record and contracted rates with the providers to price dental claims per the current dental terminology (CDT) fee schedule. Fee schedule pricing logic contains rules that retrieve provider contracted rates and procedure code rates from the evoBrix X Benefits and Reference Data Management module. Our solution can execute pricing rules set in pre-defined configurable sequences when multiple sets of rules apply to a single service line. Manual pricing will be performed when no fee schedules are available.

- **Institutional In-Patient Claims:** The evoBrix X Core Claims module is pre-configured to leverage APR-DRG 3M grouper for Inpatient pricing. The pricing methods will leverage data elements defined below to calculate the final Inpatient paid amount at a header level:
  - DRG rate factors (e.g., DRG code, Relative Weight, Length of stay).
  - Provider DRG factors (e.g., DRG base rate, operating ratio, skilled days, discharge rate)
  - Provider rates (Revenue codes for room and board)

  The system is also configured to price claims on the per diem rate on provider contracts, instead of routing the claim to the DRG grouper, for those providers without DRG assignment. This includes providers such as nursing facilities, hospice, psychiatric residential treatment facilities and rehabilitation hospitals. Our solution supports pricing of long-term care claims and hospice claims based on room and board charges and other services. Details such as the capacity of the provider's inpatient facility also play a role during pricing. All the required information is used to facilitate the pricing process.
- **Institutional Out-Patient Claims:** The evoBrix X Core Claims module prices outpatient claims at the service line level. Claims are identified for Outpatient Prospective Payment System (OPPS) pricing using claim type and provider indicators and the Revenue Fee Schedule. The solution leverages OPPS and Ambulatory Payment Classifications (APC)-related editing and pricing rules using HSS APC software for outpatient claims. This includes services rendered in Hospital outpatient departments, Ambulatory Surgery Centers, and Outpatient therapy providers such as Comprehensive Outpatient Rehabilitation Facilities. Quarterly updates published by Medicare related to OPPS/APC methodology, pricing, and editing are regularly applied. Our solution is configured to price claims at provider-specific rates, such as the encounter rate established using the clinic's current prospective payment system (PPS) for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) or the Indian Health Service all-inclusive rate (AIR) methodology for Tribal Health Centers (THC). The encounter rate will be processed based on the encounter revenue code and detail line item combination, with the payment being posted on the encounter service line. The pricing logic includes the flexibility to validate the number of encounters received in a day from the provider for the same member, along with the diagnosis. Manual pricing will be performed when no fee schedules are available.

BRDM06

The Contractor's solution shall allow automated and manual mass assignments and updates (e.g., service authorization required, medical review required, limits, diagnosis codes) to procedure code(s)/modifier(s) applied to benefit plans as defined by the Agency.

Team CNSI's evoBrix X CPMS solution facilitates benefit administration through a hierarchical structure that provides DPHHS with an online configurable functionality to define service coverage information, cost share, service limit, and funding details. Service coverage definitions can be specified at the elementary level, such as procedure code, or at a higher level, such as diagnosis code, taxonomy code, or a combination of code sets. The allowed code set categories include ICD diagnoses and procedures, HCPCS, procedure modifiers, revenue codes, bill types, places of service, provider taxonomy or specialty, claim type, revenue code and provider type.

Through online screens, authorized users can make timely changes to the plan information and offer the flexibility to DPHHS to reduce or add services, define monetary limitations, or impose premium and co-pay restrictions.

As showcased in Figure 3.10.12-8 and Figure 3.10.12-9, the benefit plan restrictions configuration has the provision to include or exclude one more category of services and code set or group of entities for a Benefit Plan.

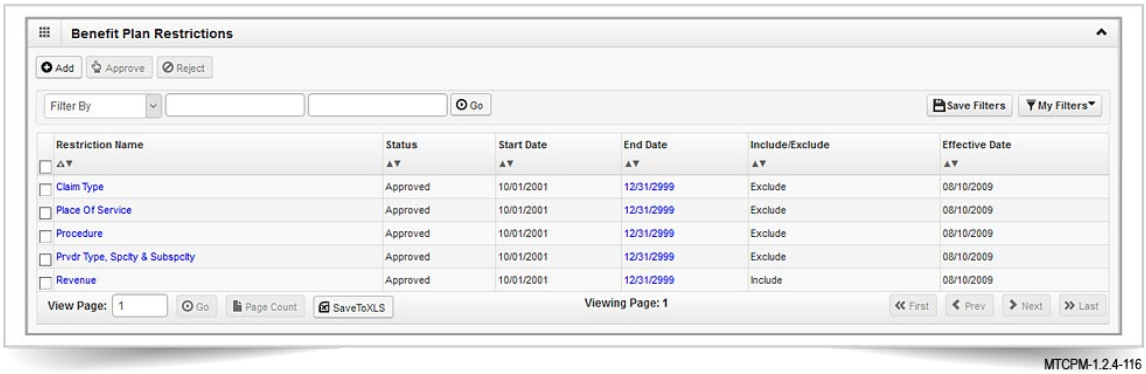


Figure 3.10.12-8. Managing Benefit Plan Restrictions. evoBrix X displays procedure codes included/ excluded in Benefit Plan restriction as part of Benefit Plan configuration.

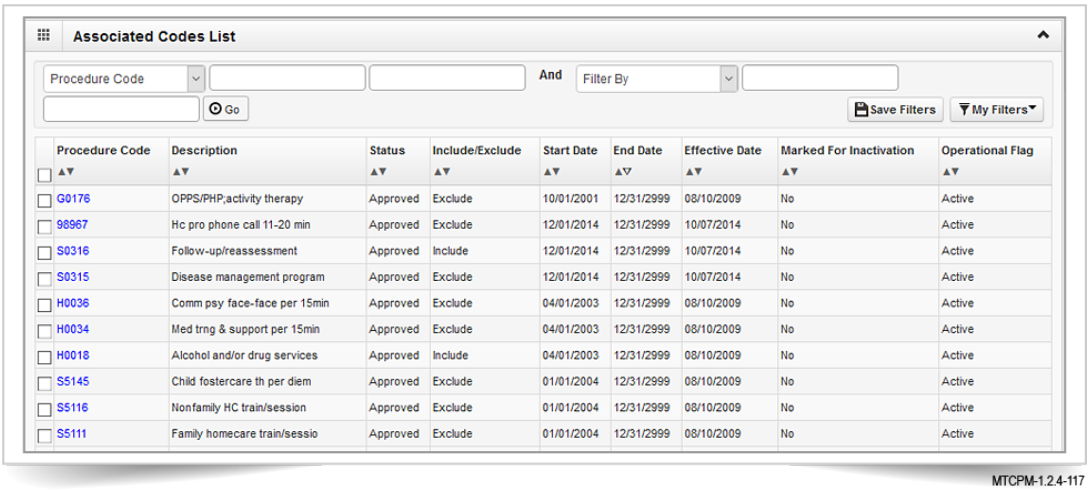


Figure 3.10.12-9. Associated Code Listing. evoBrix X defines procedure code with include/exclude category under Benefit Plan Restriction.

Regardless of whether code set changes are made online or through batch files, changes are made to the reference code sets only when authorized by DPHHS. Low-volume changes to the code sets are entered directly by Team CNSI's Business Operations staff, while batch file loading – the preferred, more efficient approach – supports high-volume changes. Any change to the National Standard code set will need to be approved by the State and only through authorized DPHHS personnel. Team CNSI will use the profiles and roles defined in the Administration area of our solution to control and regulate permissions and authorizations for users working with our MPATH solution's screens. This feature provides the State with control over access and permissions on the screen, thereby regulating the personnel who can make changes to the standard code sets.

When changes need to be applied to the evoBrix X CPMS solution using background processes, Team CNSI will work with DPHHS to develop a calendar for applying these updates. Some of the factors determining the timeline for these updates include the following:

- Size of the change
- Impact of the change on the claims that need to be adjudicated
- Impact on the change in approach for the claims processing

Team CNSI will perform an analysis pertaining to the impact of changes to the code sets and report our findings to the State. Following DPHHS review of our report and any resulting actions or measures taken, if needed, Team CNSI will finalize the date and time for when the appropriate changes need to be rolled out into production.

Any changes performed to the procedure code(s)/modifier(s) associated to the benefit plans will be automatically part of the benefits and utilized during claims adjudication process.

BRDM07

The Contractor's solution shall provide configurable business rules to allow carve out benefits and procedures (e.g., services allowed to be billed outside of a Managed Care Health plan as fee for service transactions) to benefit plans as defined by the Agency.

Team CNSI's evoBrix X CPMS solution offers the flexibility to carve out services that are not covered under Managed Care to be delivered through an FFS-based benefit plan. Our solution allows the State to tailor carve-out benefits by assigning specific service types to the FFS benefit plans. For DPHHS, our CPMS solution's configurable design facilitates MPATH's ability to effectively and efficiently support managed care programs with carved-out benefit plans (with specific effective dates and end dates). The carve out benefit plans are assigned to members based on member attributes received in the eligibility interface file. Our solution supports the ability to assign multiple benefit plans to a member. For instance, a member covered by carved out managed care plans can receive FFS-based services that are not covered through standard Medicaid benefits.

When processing claims, adjudication process verifies recipient eligibility and the managed care plan enrollment based on the service types associated at the benefit level. The system determines whether a service submitted on a claim is a carved-out service within the Managed Care Benefit Plan. When applicable, the system posts an edit for denial of the claim or a claim line. If the services are not covered under the Managed care benefit plan, the solution uses the configurable group's functionality to bypass the edits. Figure 3.10.12-10 illustrates carveout configuration for a special program, carveouts can be associated to different domains such as diagnosis code, provider type, specialty/subspecialty, procedure code, revenue codes, DRG codes, claim type and as such and can also be restricted based on age range. Figure 3.10.12-11 shows carveout configuration based on Claim Type and Provider attributes (provider type, specialty and subspecialty) and Figure 3.10.12-12 provides detailed information on the list of specialty and subspecialty combination that are part of the carve outs.

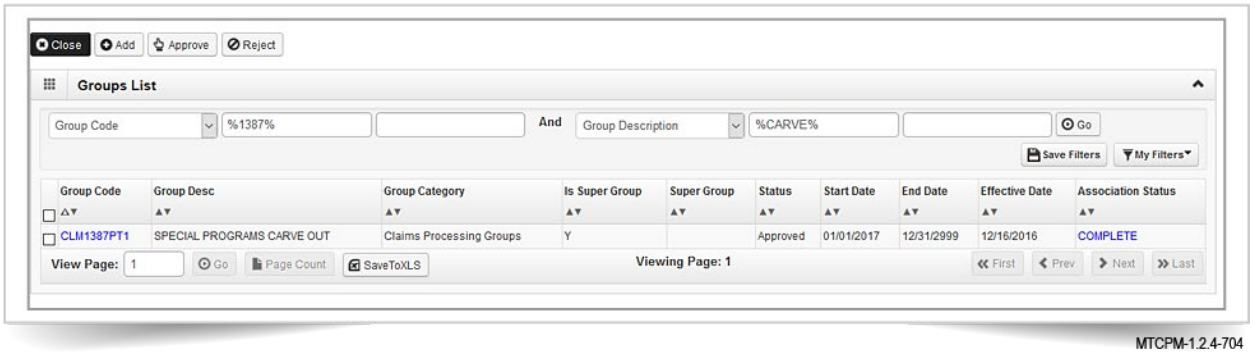


Figure 3.10.12-10. evoBrix X solution provides capabilities to define carveouts for individual programs.

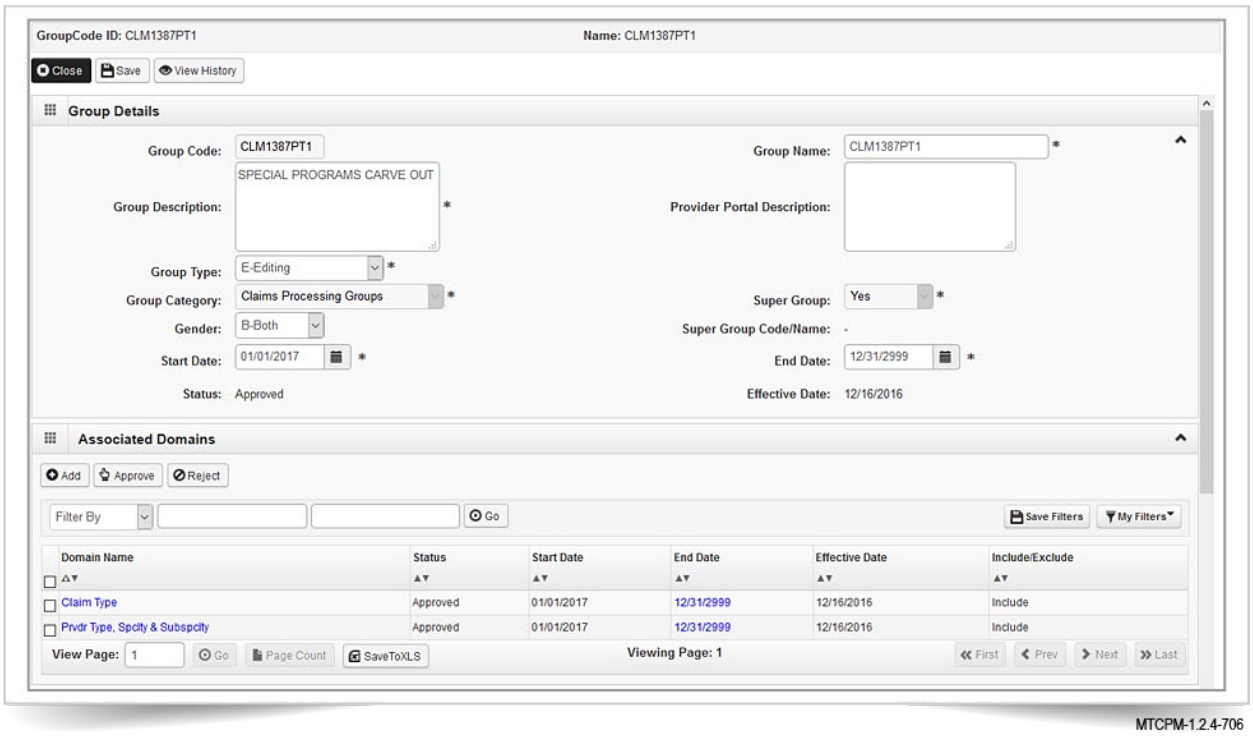


Figure 3.10.12-11. evoBrix X solution allows carve outs to be defined at a granular level and with various attributes such as provider type, claim type, diagnosis codes, procedures codes, DRG codes.

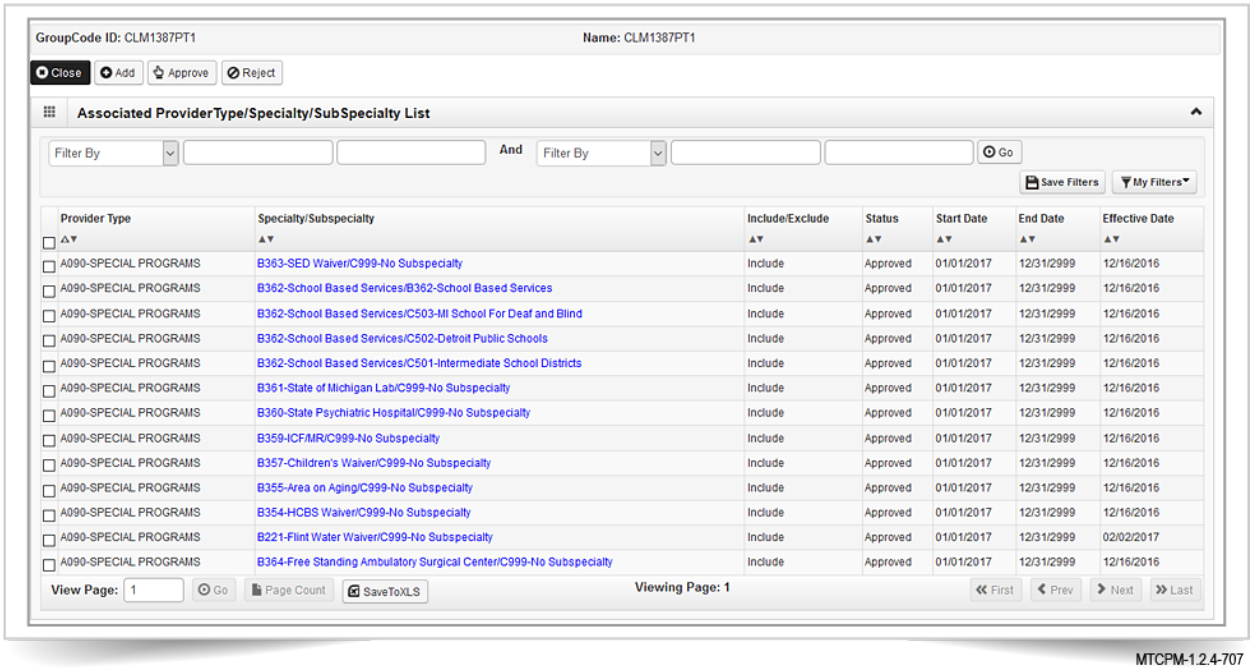


Figure 3.10.12-12. Carve-out configuration with specific specialty and sub-specialty configuration.

BRDM08

The Contractor's solution shall accept, maintain, and display eligibility and enrollment data (e.g., managed care, TPL, waiver, care programs, primary care provider, Medicare, personal resource, spend-down, buy-in) received via an interface as defined by the Agency.

Team CNSI's evoBrix X CPMS solution offers modern features that enable our system to receive member Medicaid/waiver eligibility and enrollment data in both batch and real time. Our proposed solution assumes that CNSI will receive all Managed Care enrollments in a mutually agreed upon interface layout. Figure 3.10.12-13 illustrates the history of eligibilities assigned to a member. Our solution maintains the history of member eligibility with effective date, end date and the date for each eligibility/enrollment transaction. The solution will be further customized to accept different feeds from multiple sources.

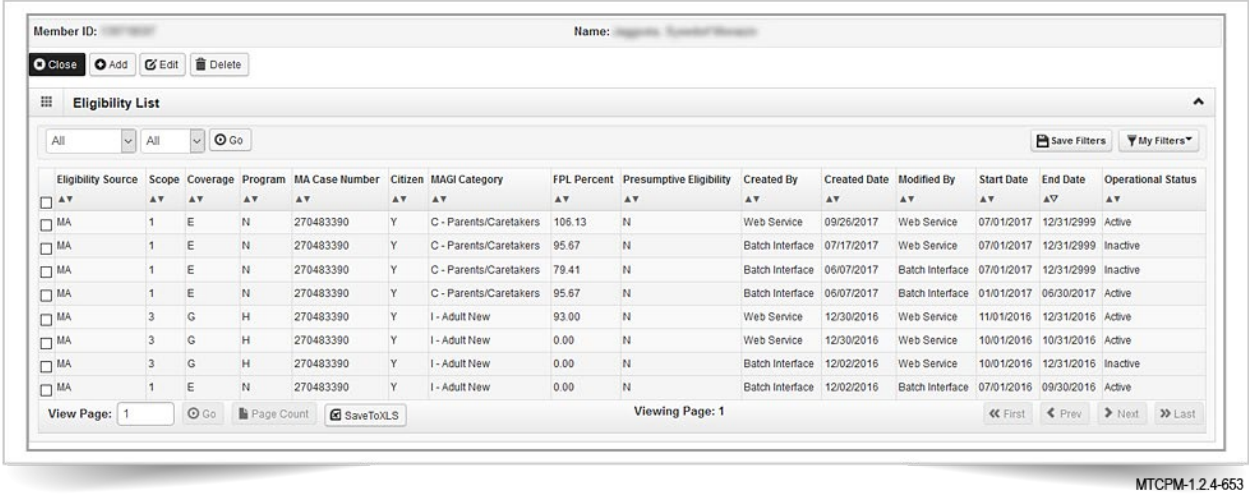


Figure 3.10.12-13. Eligibility List. evoBrix X allows users to view the history of member eligibility.

evoBrix X receives, stores and displays eligibility data and maintains the history with effective date and end date. Team CNSI's evoBrix X solution can display various configurable eligibility parameters such as Type of Assistance (TOA), Recipient Aid Category (RAC), Eligibility Aid Category (EAC), Category of Assistance (COA), Scope, Coverage and Program.

Along with the eligibility and enrollment data, our solution can receive and store Primary Care Provider (PCP) information from Managed Care Organizations or CEB with the health plan association. Figure 3.10.12-14 illustrates the Primary Care Provider information that are stored and displayed in the system.

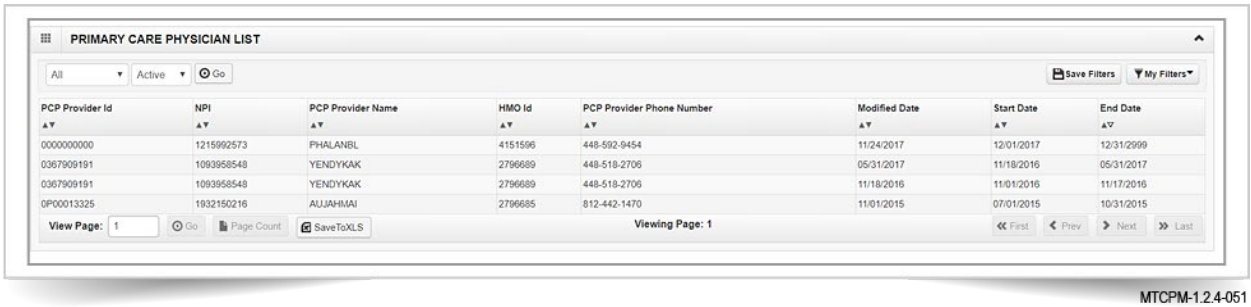


Figure 3.10.12-14. Primary Care Physician list. evoBrix X receives, stores and displays PCP information MCOs and CEB

Our solution can capture spend-down member information with spend-down Amount (SDA) and Buy-In information received in eligibility interface and displays the data in Member Eligibility and Demographic information screen. Similarly, the system is equipped to handle Medicare and private/employer sponsored TPL information with the following details.

- Coverage type
- Payer Information
- Effective Date and End Date
- Pharmacy copay/deductible information
- Primary Policy Holder
- Policy Holder Employer Information

Third-party insurance details are maintained in a member-centric manner. **Error! Reference source not found.**describes the third-party insurance details that are stored and linked to the appropriate member.

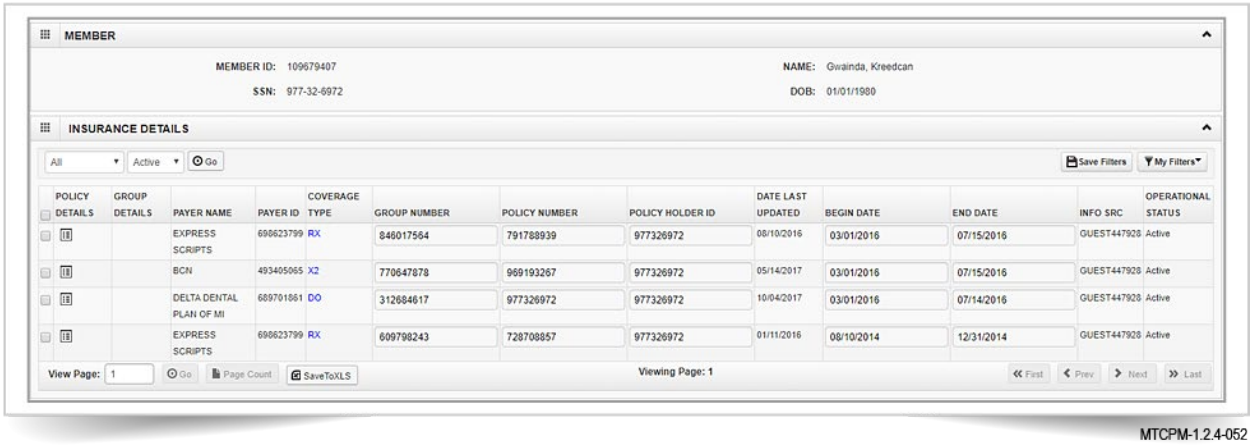


Figure 3.10.12-15. Third Party Liability Information. Team CNSI's evoBrix X solution can receive TPL information from CMS MMA/TBQ and private insurance through interface or using UI screens.

BRDM09

The Contractor's solution shall provide configurable benefit and service restriction (e.g., third party liability, lock-in or lock-out, managed care, benefit plan, limits) responses in response to an eligibility inquiry made through a service or a web portal based on Agency defined configurable business rules.

Team CNSI's evoBrix X CPMS solution provides the capability to configure and respond to eligibility inquiries based on the information available in the system. The response will include Fee for Service, Managed Care and No-Benefit Benefit Plans along with service type restrictions, covered and non-covered service types, Primary Care Provider, Lock-in or Lock-out provider restrictions, TPL Medicare/private insurance and Copay etc. through either a web portal or HIPAA 270/271 transaction or through a service. Figure 3.10.12-16 illustrates the response to a provider inquiry.

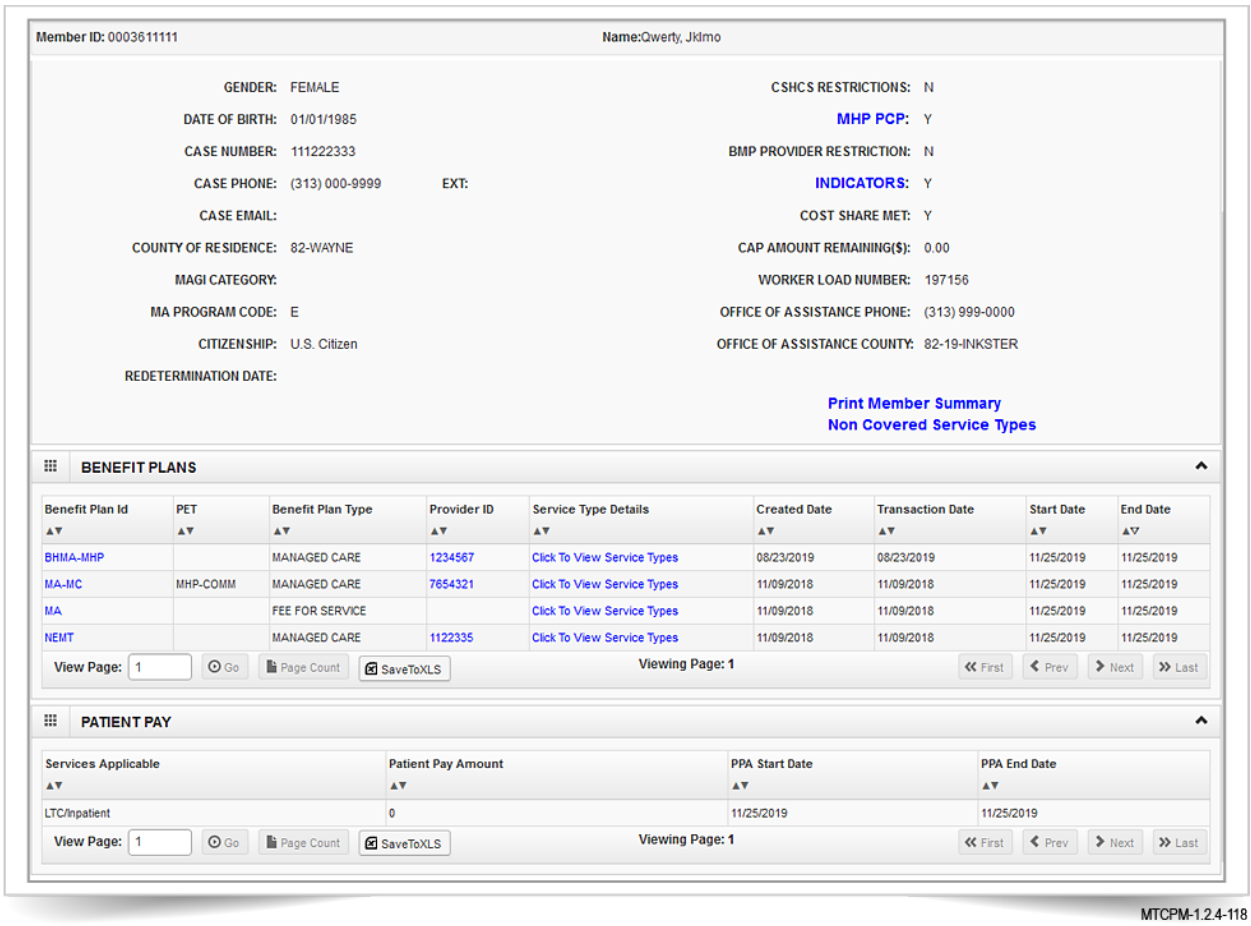


Figure 3.10.12-16. Eligibility Inquiry Details

Our solution also provides a detailed summary that includes diagnostic codes, locked-in providers and list of TPL applicable for the service period. Figure 3.10.12-17 illustrates the summary information provided as part of inquiry response.

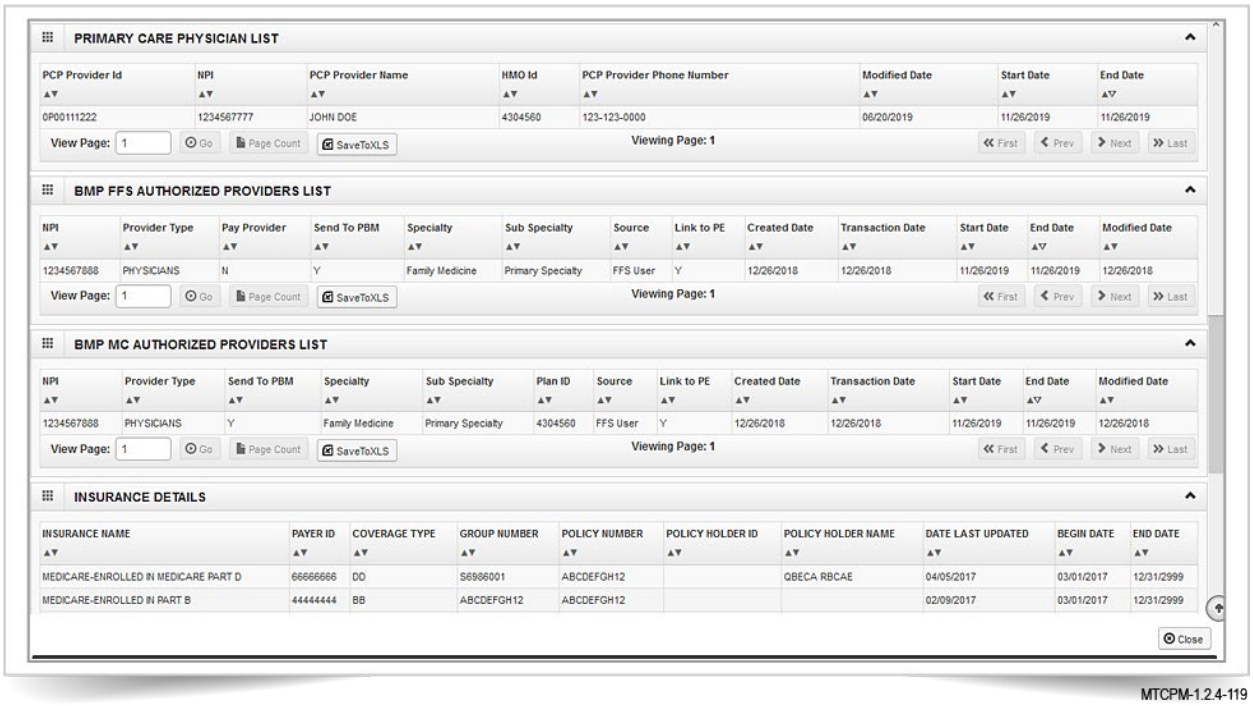


Figure 3.10.12-17. Screenshot of evoBrix X Providing Granular Information on TPL, PCP, Lock-in Providers etc. for an eligibility inquiry submitted through web portal.

Our solution tracks eligibility inquiry request submitted through web portal at a granular level for auditing by logging requesting provider information, member attributes that were used to submit the request, inquired date of service and the service types requested. This audit data can be used to generate reports on eligibility inquiry submitted to web portal in a given time span.

BRDM10

The Contractor's solution shall update, store, maintain, and display indicators for benefit plans (e.g., procedure include/exclude indicators, modifiers, clinical or utilization and special needs status) as defined by the Agency.

Team CNSI's evoBrix X CPMS solution provides the ability to maintain indicators for benefit plans. Our solution also provides the ability to maintain an exception list of beneficiaries, services, or procedure codes, modifiers using the include/exclude feature, which is used during benefit plan assignment and claims adjudication process.

The benefit plan restrictions functionality provides the flexibility to define covered services and service limitations. The service coverage definitions could be specified at the elementary level, such as procedure code, or at a higher level such as diagnosis code, taxonomy code, or a combination of code sets. The allowed code set categories include ICD diagnoses and procedures, HCPCS, procedure modifiers, revenue codes, bill types, places of service, provider taxonomy or specialty, claim type, revenue code, and provider type. Figure 3.10.12-18 presents procedure codes that are included/excluded in Benefit Plan restriction as part of Benefit Plan configuration.

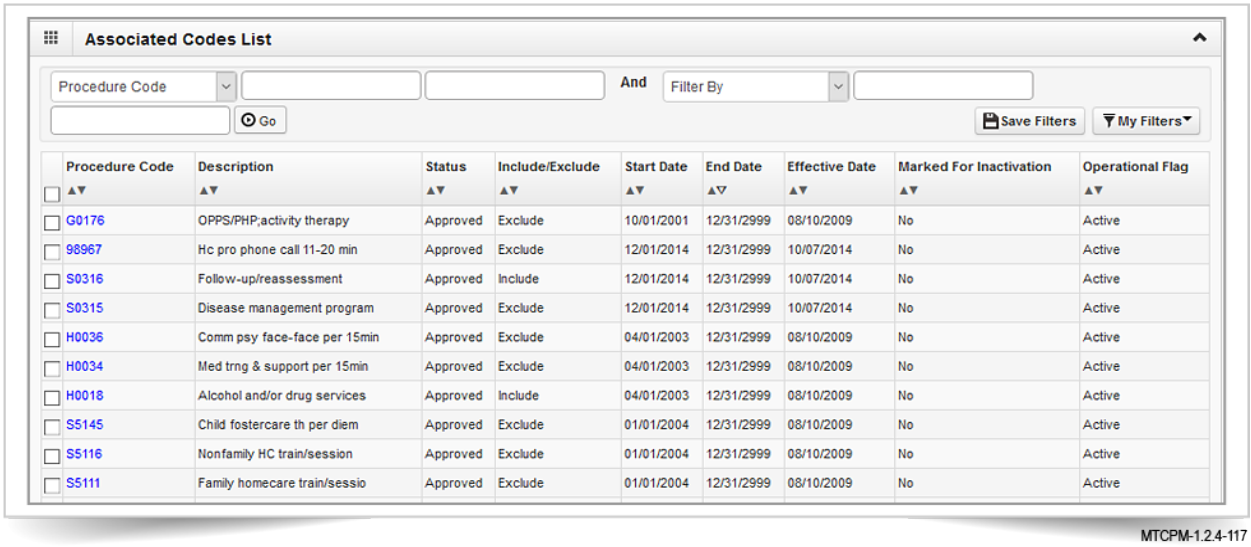


Figure 3.10.12-18. Associated Code List. Our Core Claims solution defines procedure code with an include/exclude category under Benefit Plan Restrictions.

BRDM11

The Contractor's solution shall create, maintain, and update reference tables with varying federal financial participation rates (e.g., procedure or combinations of procedures, modifier or combinations of modifiers, diagnoses, category of service, benefit plan, waivers, provider type, provider specialty, member demographics) as defined by the Agency.

Team CNSI's evoBrix X Benefits and Reference Data Management module provides multiple pricing options as listed below. Authorized users can manage and view this information through specific screens. These Rate Setting screens allow for configuration of the factors used to calculate the correct rate for the service performed. Figure 3.10.12-19 lists the rate setting functionality available in the evoBrix X solution.

Benefit Plan Rates	Allows configuration of procedure rates at Benefit Plan level. This provides the flexibility of configurating rates based on eligibility criteria, provider network, reimbursement rules and medical policy.
Code Rates	Code rates are used to specify rates by procedure code, revenue code, ICD-9/ICD-10 surgical codes, and DRG codes with rate type (value ($) or factor (%)) and association of additional modifiers, claim types and providers/member attributes such as age range, place of service, residence county.
DRG Rate Factors	Allow configuring the factors to calculate DRG rates during the claims adjudication process include Provider NPI, relative weight alternative relative weight, low day, high day, alternate low day, alternate high day, average length of stay, alternate length of stay, and percentage charge.
Group Rates	Allows setting up rates based on grouping multiple codes, modifiers and age factor with a rate type (value ($) or factor (%))
Managed Care Rates	Allows configuration of rates for defined managed care programs with based rate and additional rate factors-based member demographic such as region/county, age, gender etc.
Member Rates	Allows configuration of member specific rates with effective date and end date and/or

	tied to a provider NPI and/or tied to a service with rate type (value ($) or factor (%))
Provider DRG Factors	Factors used in Provider DRG rates include DRG base, inpatient operating ratio, rehab base rate, rehab operating ratio, and outpatient ratio. This new screen accommodates the display of the factor values used to calculate the Provider DRG reimbursement during claim adjudication.

Figure 3.10.12-19.evoBrix X Rate Setting. Users can set and manage reference data for a variety of different rate settings.

Our solution has the capability to receive fee schedules and different types of rates through automated batch processes using the Interface. Figure 3.10.12-20 illustrates the provider rates that can be maintained in the system.

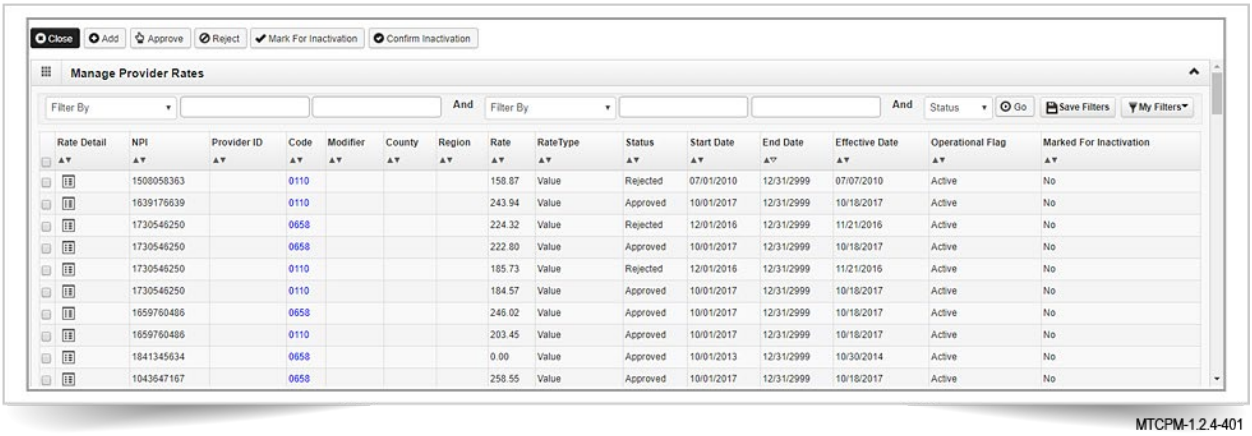


Figure 3.10.12-20. Manage Provider Rates Screen

These rate types can be defined based on various attributes that are listed below. Many of the listed data elements can be configured individually or in conjunction with another data element to setup the rates. For instance, Provider Rates can be created with a combination of specialty/sub-specialty and procedure codes and service region/place of service. The available data elements for such configuration are (but not limited to):

- Provider NPI or ID
- Provider Location
- Specialty
- Procedure/Service Code Modifier
- Claim Type
- Age Range
- Rate Type Category
- Value or Percentage
- County of Beneficiary
- Region of Beneficiary
- Member Demographics (Age, Gender [MC factors])
- Date of Service – all rates are based on dates of service

Figure 3.10.12-21 illustrates the configuration and maintenance of Procedure/Revenue codes with other provider attributes/member demographics such as place of service, Age of the member and the county of residence.

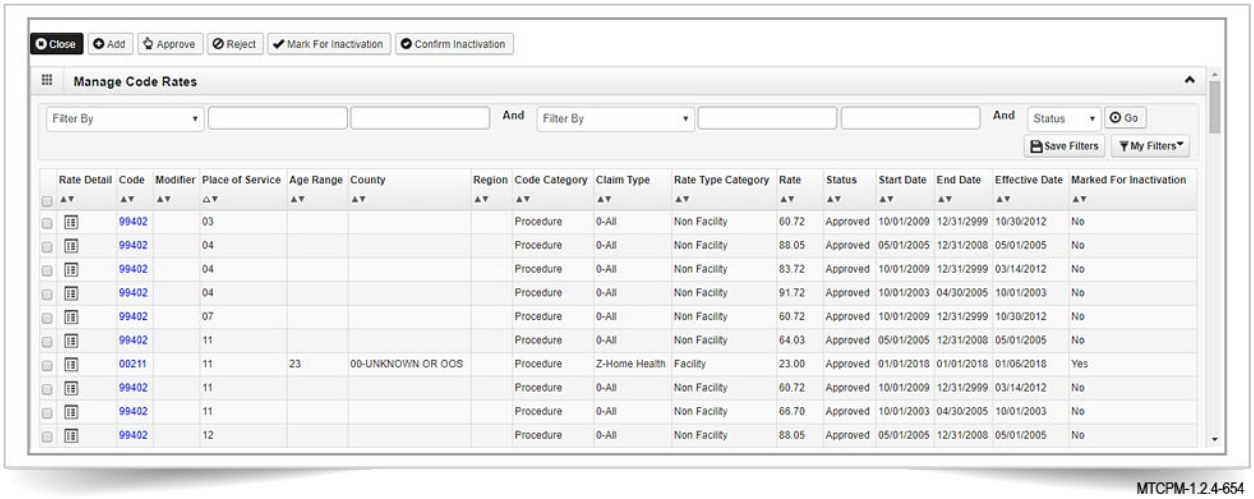


Figure 3.10.12-21. Manage Code Rates Screen

Figure 3.10.12-22 illustrates the configuration and maintenance of Specialty Rates.

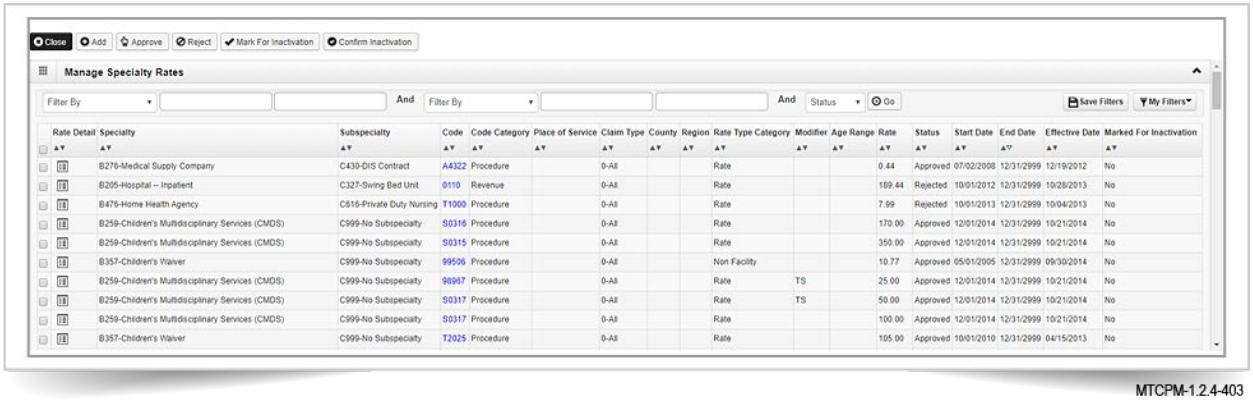


Figure 3.10.12-22. Manage Specialty Rates Screen

BRDM12

The Contractor's solution shall store, maintain, and display date sensitive parameters (e.g., effective date, beginning and end date, change date) for each occurrence of all reference data (e.g., benefit plan, procedure, reimbursement methodology) as defined by the Agency.

The evoBrix X CPMS solution captures and stores all records with effective date and end date. All additions and modifications are date tracked with complete history. Any reference date set such as benefit plans, code rates, code sets, service types are maintained with created date, effective date, end date and modified date along with created by and modified by information. This feature enables our solution to track the changes and meet the State's requirement of maintaining the history of changes.

Figure 3.10.12-23 shows the procedure code's history information along with effective date and end date as and when a rate change occurs.

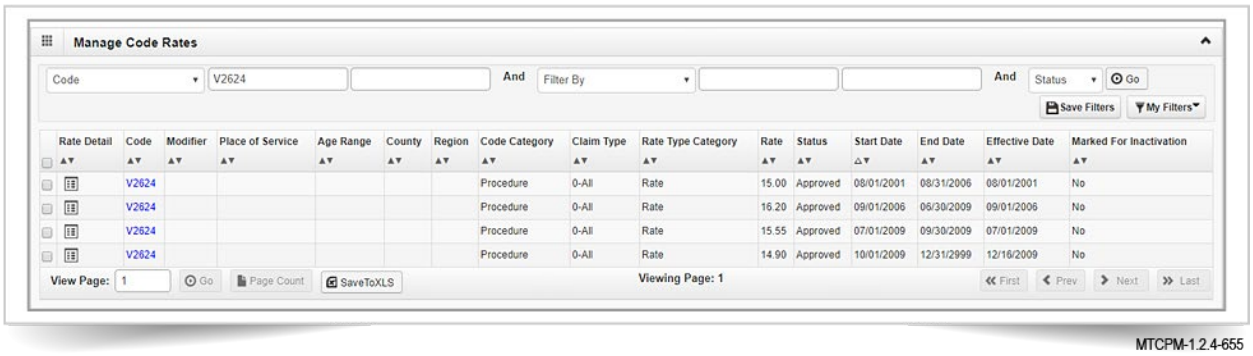


Figure 3.10.12-23. Code Rates Configuration

Figure 3.10.12-24 shows the list of Benefit Plans with their status, start and end dates along with the effective date.

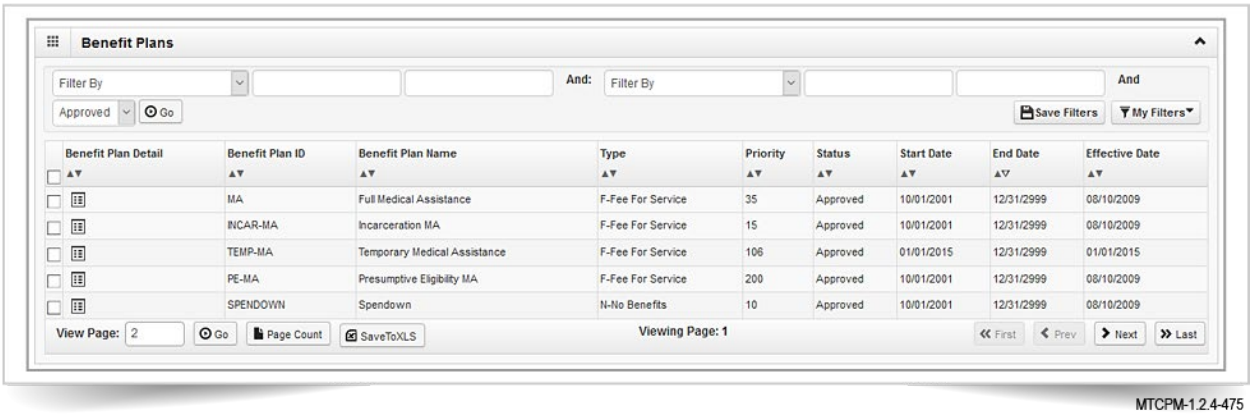


Figure 3.10.12-24. Benefit Plan Details along with status and start and end dates

BRDM13

The Contractor's solution shall have the ability to maintain and cross reference multiple Member identifiers and aliases.

Team CNSI's evoBrix X CPMS solution provides the capability to store multiple Member Identifiers to help identifying duplicate data and data discrepancies via a member match algorithm that includes invalid, duplicate, or overlapping records with issues in multiple data elements, including address, name, other demographic or identifier information. Few of the key Member Identifier are listed below:

- Member Medicaid ID
- SSN
- Medicaid Case Number
- Client Identification Number
- MBI (Medicare Beneficiary Identifier)
- HIC Number

Figure 3.10.12-25 illustrates various identifiers captured for a member.

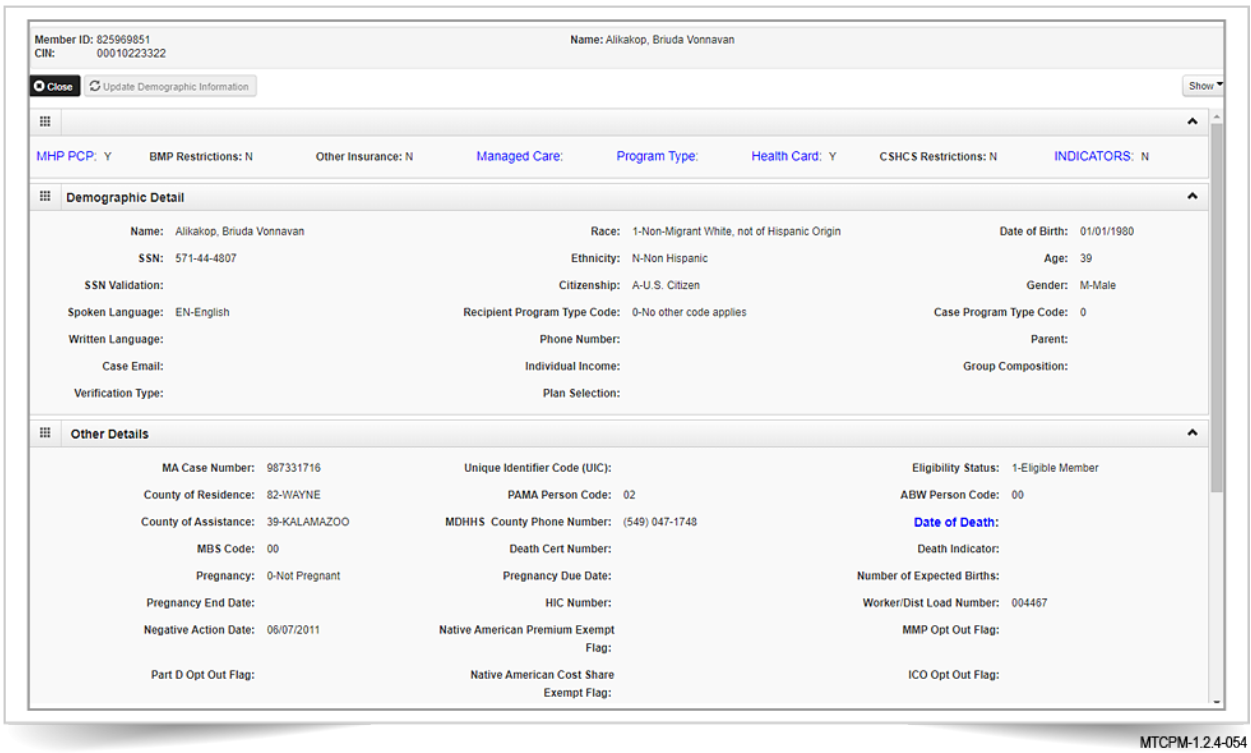


Figure 3.10.12-25. evoBrix X Manages Member Information. The evoBrix X CPMS solution enables maintenance and cross-referencing of multiple Member identifiers, including aliases.

BRDM14

The Contractor's solution shall produce and distribute replacement state healthcare program member identification cards in an-Agency defined timeframe.

Team CNSI's evoBrix X CPMS solution will generate and distribute Medicaid ID cards for new enrolled members and provide the ability for the members to request for a replacement ID card using the evoBrix X member portal. All the card requests are captured in the system and processed through our print and mail vendor. The requests are received either via a batch file or a real time service from the State through evoBrix X ISR framework. The evoBrix X solution will maintain the history of replacement ID card request for any member with detailed information such as request date, requested by, request reason (lost, stolen, damaged/destroyed, name change, new member etc.), address, processed date, dispatched date and issue count. Figure 3.10.12-26 illustrates card issuance details at member level.

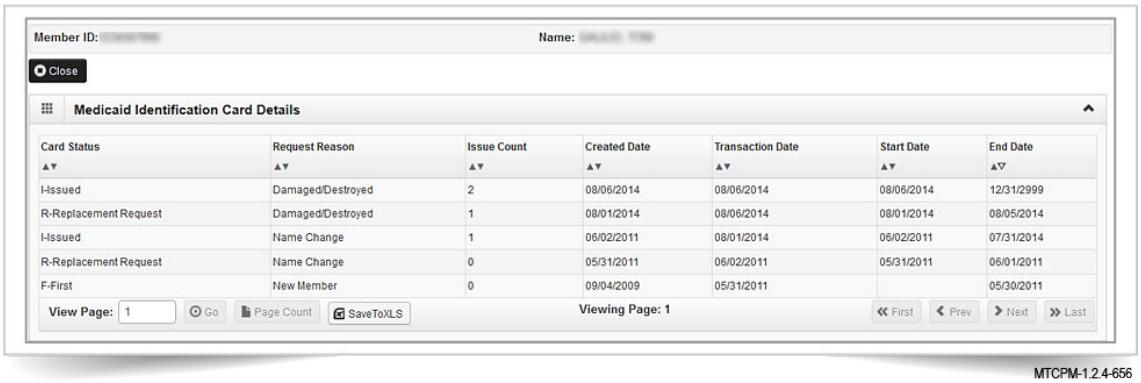


Figure 3.10.12-26. Medicaid Identification Card Details.

The Medicaid ID Cards will be generated on a schedule determined by program and policy, as defined by DPHHS.

BRDM15

The Contractor's solution shall produce and distribute state healthcare program member identification cards and associated materials as defined by the Agency.

Team CNSI's evoBrix X CPMS solution will generate and distribute Medicaid ID cards for new enrolled members and provide the ability for the members to request for a replacement ID card using the evoBrix X member portal. All the card requests are captured in the system and processed through our print and mail vendor. The requests are received either via a batch file or a real time service from the State through evoBrix X ISR framework. The evoBrix X solution will maintain the history of replacement ID card request for any member with detailed information such as request date, requested by, request reason (lost, stolen, damaged/destroyed, name change, new member etc.), address, processed date, dispatched date and issue count. Figure 3.10.12-27 illustrates the screen that provides detailed information on member Medicaid identification.

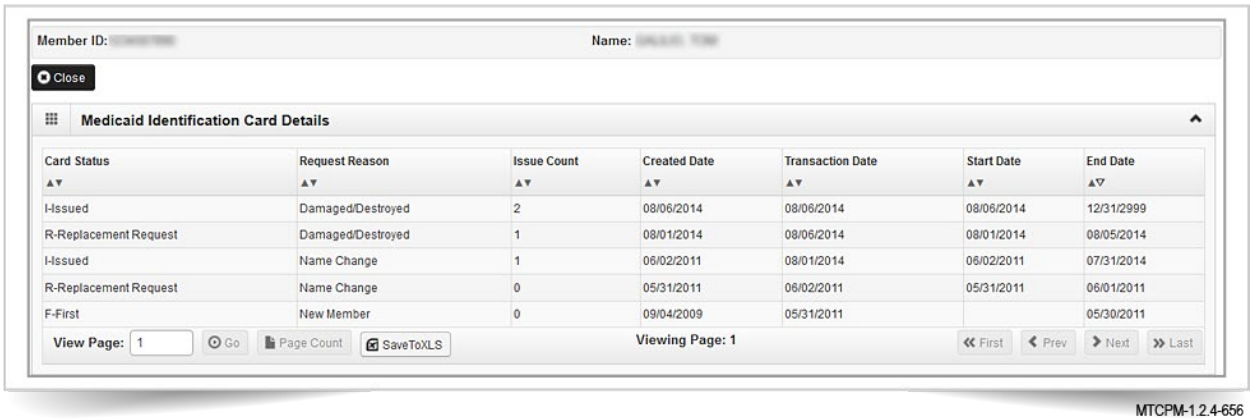


Figure 3.10.12-27. Medicaid Identification Card Details. evoBrix X provides detailed information on the transactional history for Medicaid Identification cards.

Team CNSI will work with DPHHS on finalizing the materials that should be distributed along with new healthcare program member identification cards. Team CNSI will generate/print and mail the Medicaid cards and the associated materials as a packet.

BRDM16

The Contractor's solution shall allow categories of service to be defined by parameters based on Agency-defined configurable business rules including:

a. Grouping various combinations of individual and ranges of codes into categories of service, including ICD diagnoses and procedures, HCPCS, procedure modifiers, revenue codes, bill types, places of service, Provider taxonomy or specialty;

b. Allow one or more categories of service to be assigned to a benefit plan as either included or excluded for the benefit plan;

c. Allow sub-groupings and individual or ranges of codes within a category of service to be included or excluded.

Team CNSI's evoBrix X CPMS solution allows the Agency to define service types and provider types applicable for a benefit plan. Service types are configured for the benefit plans using online screens which

defines the services (medical/DME/Ambulance) covered under the benefit plan as shown in Figure 3.10.12-28. Each service type under the benefit plan can be associated with groups (Service Type Code) as shown in Figure 3.10.12-29. Groups are setup in evoBrix X Benefits and Reference Data Management module to include all the services and provider specialties applicable for a given service type. The provider specialties and services can be associated to a group as domain as shown in Figure 3.10.12-30. A group will include all the services (based on ICD diagnoses and procedures, HCPCS, procedure modifiers, revenue codes) and provider type appropriate for the benefit plan as shown in Figure 3.10.12-31, Figure 3.10.12-32 and Figure 3.10.12-33. During claim adjudication, the System identifies the benefit plan and the associated service types for the benefit plan. Once the service type is identified, System identifies the group associated with the benefit plan and consider only those rules defined in the group to price the claim. If the claim fails, the criteria defined in the group then the claim will be automatically denied. Agency can create separate groups for each service type (Medical/DME/Ambulance) under the benefit plan and list all the applicable services and provider types.

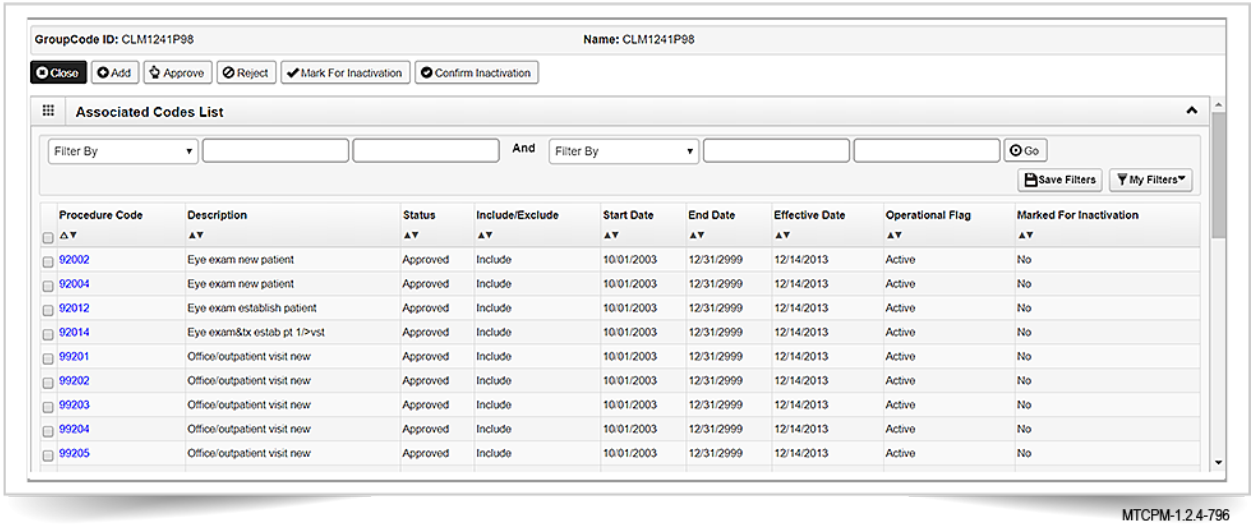


Figure 3.10.12-28.Associated Codes List.

The solution also allows the Agency to place restriction on services, provider types and member cost sharing even at the benefit plan level. It ensures that these restrictions are applicable for all the service types covered under that benefit plan. However, the groups will define the services and provider types for each service type under the benefit plan.

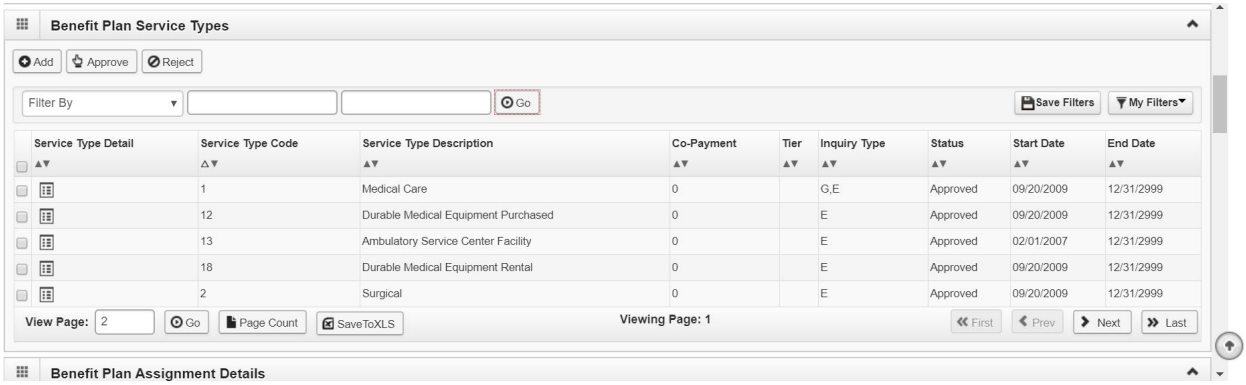


Figure 3.10.12-29. Benefit Plan Details. Service Type association with the Benefit Plan

.

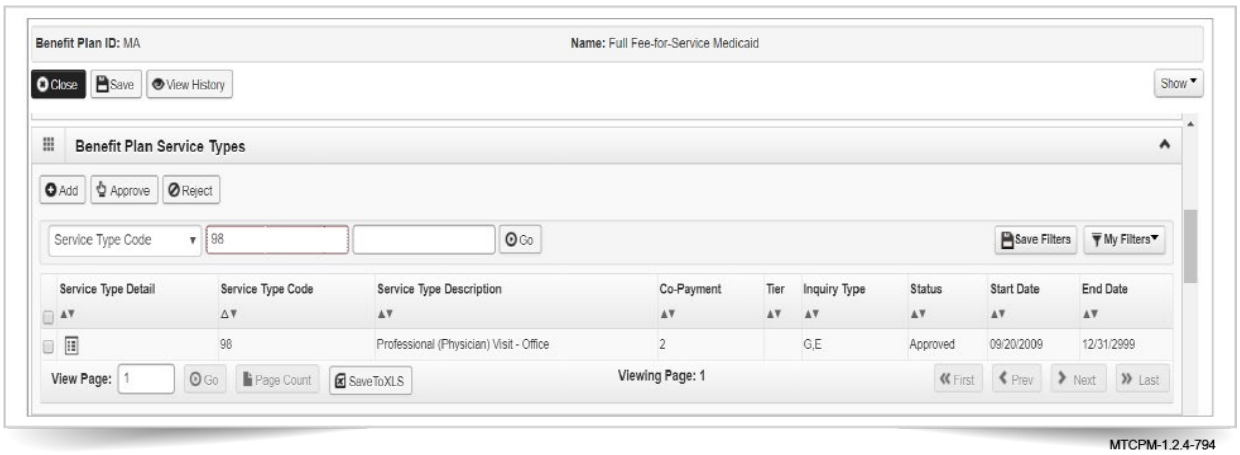


Figure 3.10.12-30. Benefit Plan Details. Service Type Code (Group) association to the Service Type.

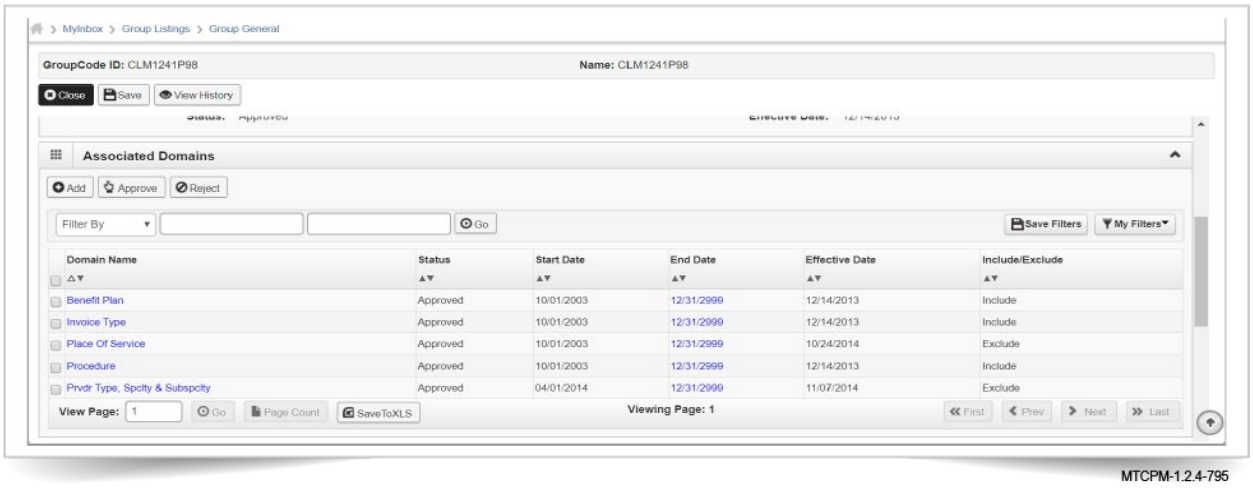


Figure 3.10.12-31. Group Details. Procedure and Provider Type Domains association with Group (Service Type Code).

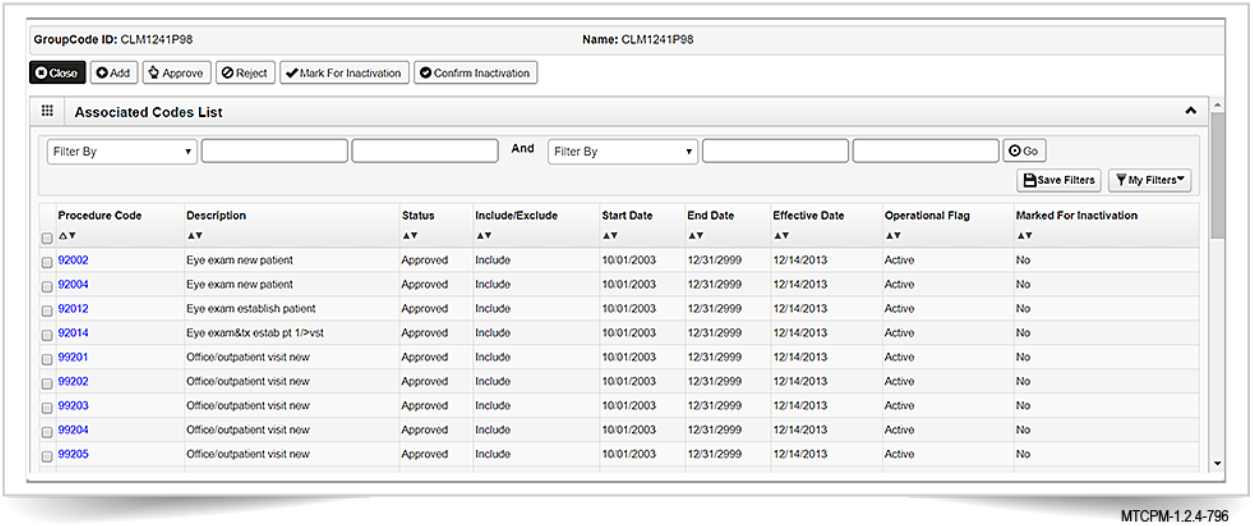


Figure 3.10.12-32. Procedure Codes associated with the Procedure Domain.

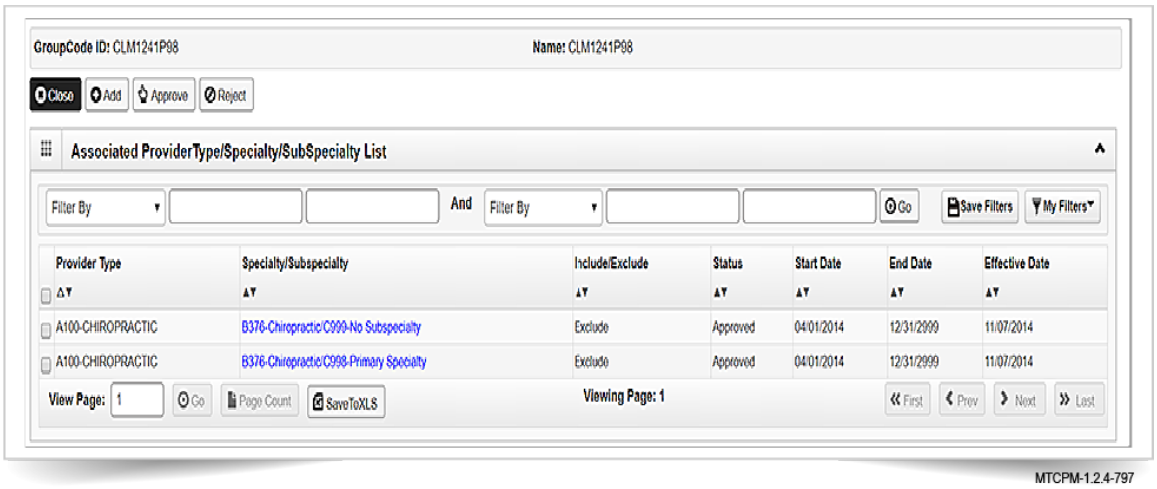


Figure 3.10.12-33. Provider Type/Specialty/SubSpecialty associated with the Provider Type Domain

As showcased in Figure 3.10.12-34 and Figure 3.10.12-35, the benefit plan restrictions configuration has the provision to include or exclude one more category of services and code set or group of entities at the Benefit Plan level.

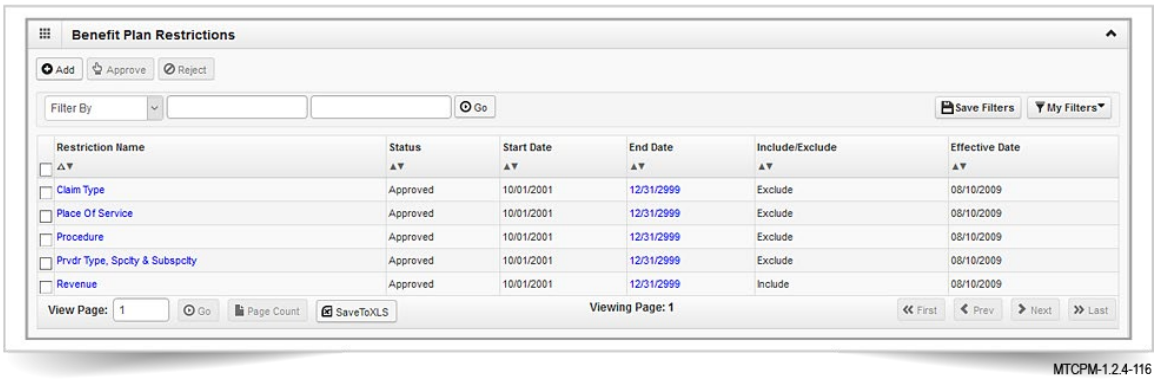


Figure 3.10.12-34. Managing Benefit Plan Restrictions. evoBrix X Benefits and Reference Data Management module displays procedure codes included/ excluded in Benefit Plan restriction as part of Benefit Plan configuration.

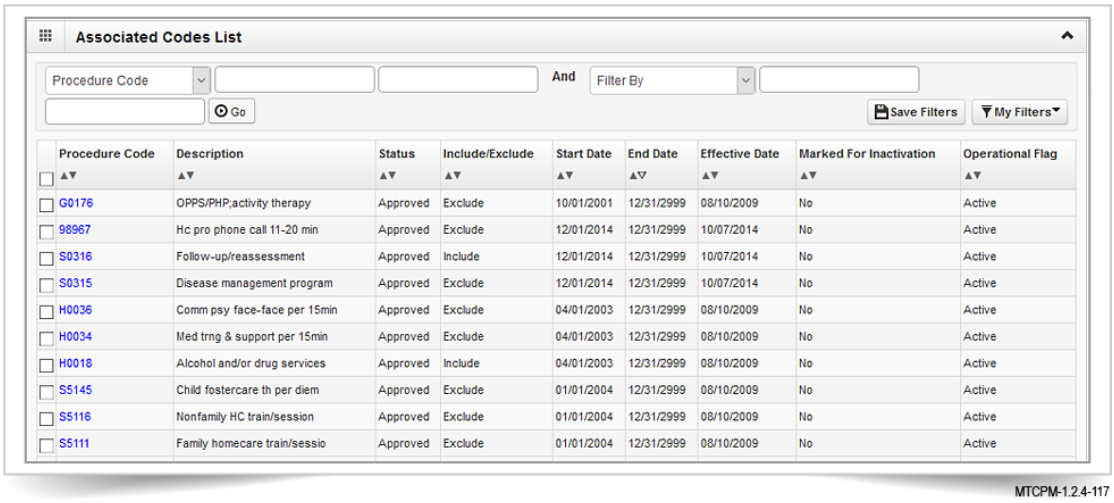


Figure 3.10.12-35. Associated Code Listing. evoBrix X Benefits and Reference Data Management module defines procedure code with include/exclude category under Benefit Plan Restriction.

BRDM17

The Contractor's solution shall allow configurable service limitations and parameters (e.g., specifying limitations, including units, dollars, occurrences, and per day maximums to categories of service and specific sub-grouping(s) and individual or ranges of codes within a category of service or benefit plan, specifying cost sharing parameters such as copay, coinsurance, and deductible, by unit, occurrence, day, length of stay, or other parameters as defined by the Agency.

The evoBrix X CPMS solution handles service limitations by configured limit definition. Limits are established with a combination of factors that can be configured to establish appropriate limit verification. These factors can include various periods, including lifetime, year, month, state or federal fiscal year, or school year. Limits can be set up for units or dollars with the same provider, any provider, or servicing provider. Once a member utilizes all units or dollar amounts defined for a service, the claim adjudication process posts the edit.

The system can create groups which can be configured to include sets of process, modifier, DRG and various other domains and beneficiary age ranges. These groups can be used in limit codes to ensure that all the rules defined for the limit code is applicable only to the procedures as that are configured in the groups associated to the limit codes. Figure 3.10.12-36, Figure 3.10.12-37 and Figure 3.10.12-38 illustrate this functionality.

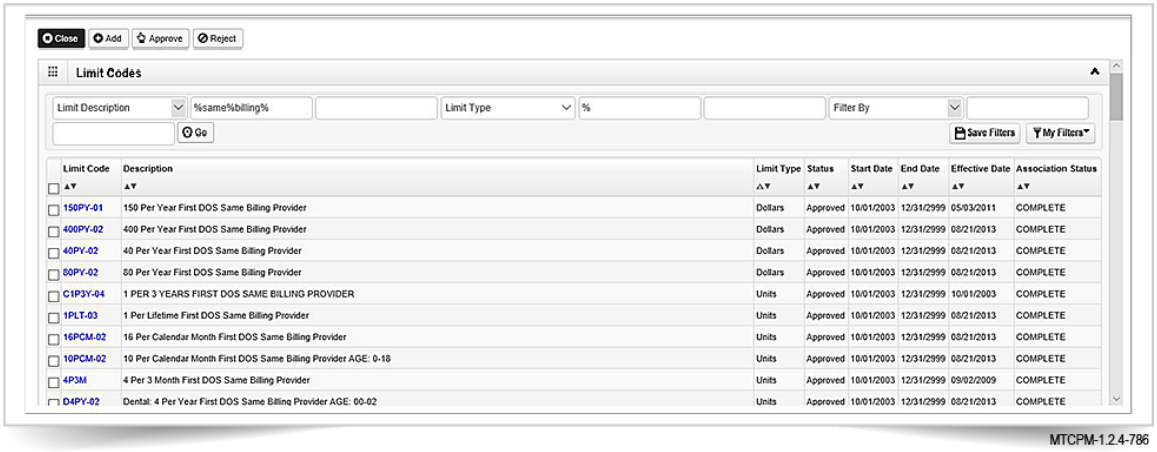


Figure 3.10.12-36. Limit Codes Screen in evoBrix X Benefits and Reference Data Management Module.

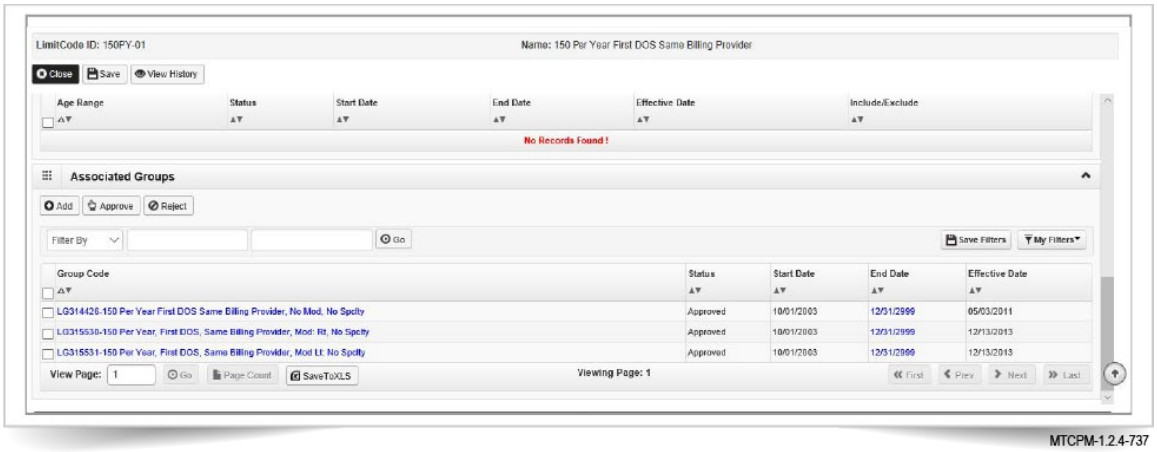


Figure 3.10.12-37. Limit Details Screen in evoBrix X Benefits and Reference Data Management module. Group Configurations for a given Limit code.

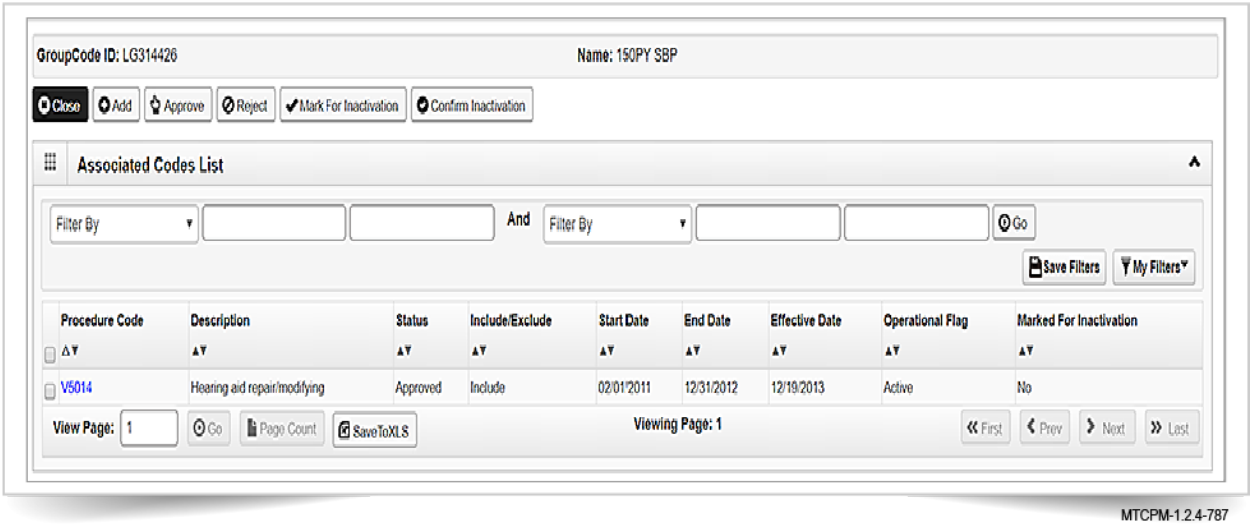


Figure 3.10.12-38. List of Associated Procedure Codes to a Group. The evoBrix X Benefits and Reference Data Management module configures the inclusion/ exclusion and start/end/effective dates of Procedures Codes.

Our solution allows service level copay configuration through Benefit Plan setup. Figure 3.10.12-39 illustrates the capability to configure individual copays/co-insurance.

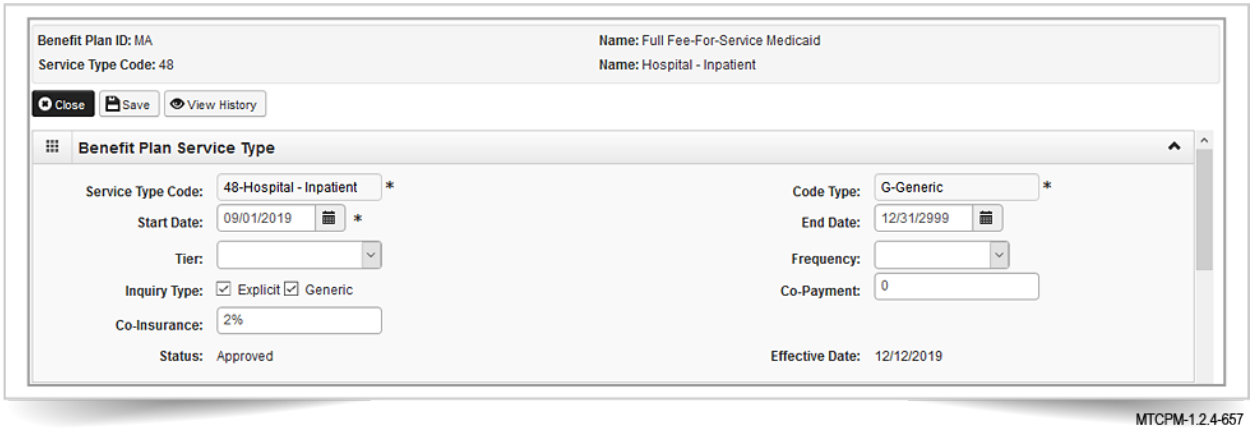


Figure 3.10.12-39. Benefit Plan Service Type Screen. evoBrix X Benefits and Reference Data Management module can configure copay/co-insurance to a specific benefit plan service types.

BRDM18

The Contractor's solution shall provide a free-form text narrative at the Benefit Plan level as defined by the Agency.

Team CNSI's evoBrix X CPMS solution allows authorized users from DPHHS to enter free-form text either as a description or as remarks while defining a benefit plan. Changes to these free-form text follows approval workflow and the history is maintained with-in the system.

These descriptions are also visible to the providers when inquired using the evoBrix X CPMS solution's eligibility inquiry web portal.

Figure 3.10.12-40 illustrates the configuration of Benefit Plan with free-form text fields.

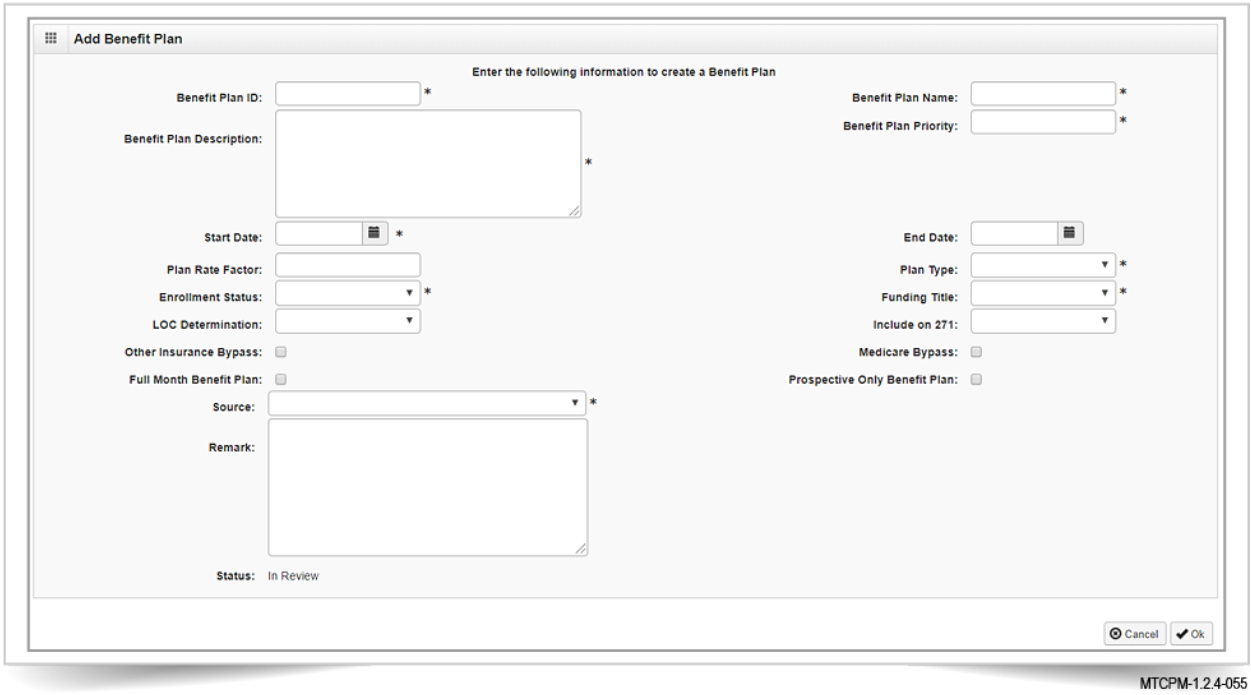


Figure 3.10.12-40. Benefit Plan Add Screen. evoBrix X CMPS solution enables the adding of benefit plans and their respective information.

BRDM19

The Contractor shall create, store, and maintain trauma indicators, including effective and end dates, ICD external cause codes, or other indicators used for identifying potential TPL cases as defined by the Agency.

Team CNSI's evoBrix X CPMS solution includes maintaining and managing reference data through online screens. ICD-10 codes are maintained along with trauma codes, external cause of injury and place of occurrence codes and all other metadata approved by state authorized users through reference data management. Each code includes fields for short description, association status and effective start and end dates.

Our solution is pre-loaded with a wide variety of TPL edits as part of its overall library of claims adjudication edits. These edits are configured in the evoBrix X RuleIT engine, and include cases of identifying claims coded with primary diagnosis as external cause codes and denying them. These edits also include cases of validating additional information on claims billed with external cause codes as secondary diagnosis.

For instance, a pre-configured "TPL Suspect" edit identifies potential cases of TPL coverage based on claims having related cause codes of Auto Accident, along with occurrence codes of Accident/Medical Coverage, No Fault Insurance Involved - Including Auto Accident/Other, Accident/Tort Liability, or Accident/Employment Related.

During Implementation, based on review of existing TPL edits with DPHHS, we can configure new edits to meet additional requirements see Figure 3.10.12-41.

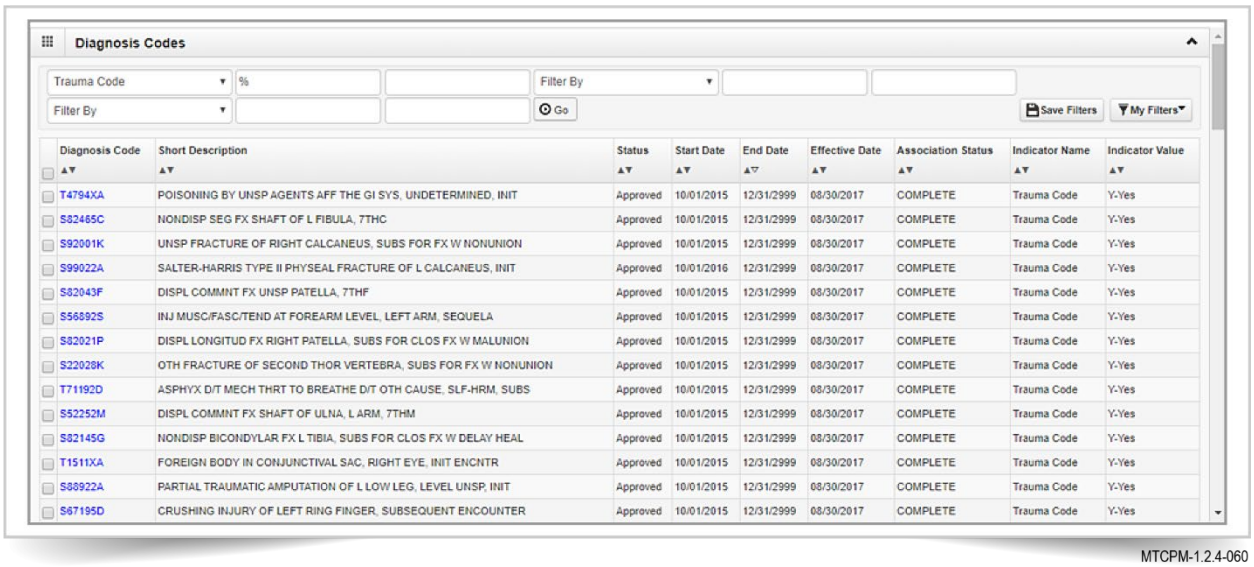


Figure 3.10.12-41. Diagnosis Code and Trauma Code indicator.

Figure 3.10.12-42 illustrates how the evoBrix X solution allows users to store and maintain various categories of diagnosis codes.

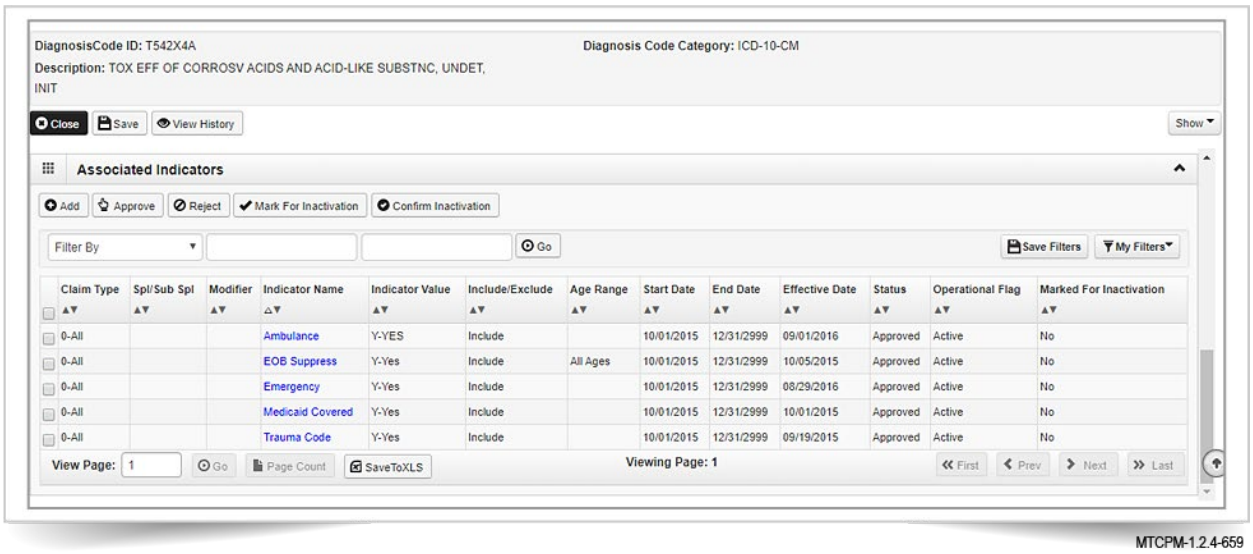


Figure 3.10.12-42. Diagnosis Codes and associated indicators. evoBrix X Benefits and Reference Data Management module stores and maintains diagnosis codes with additional indicator associations such as Trauma code, Ambulance, Emergency.

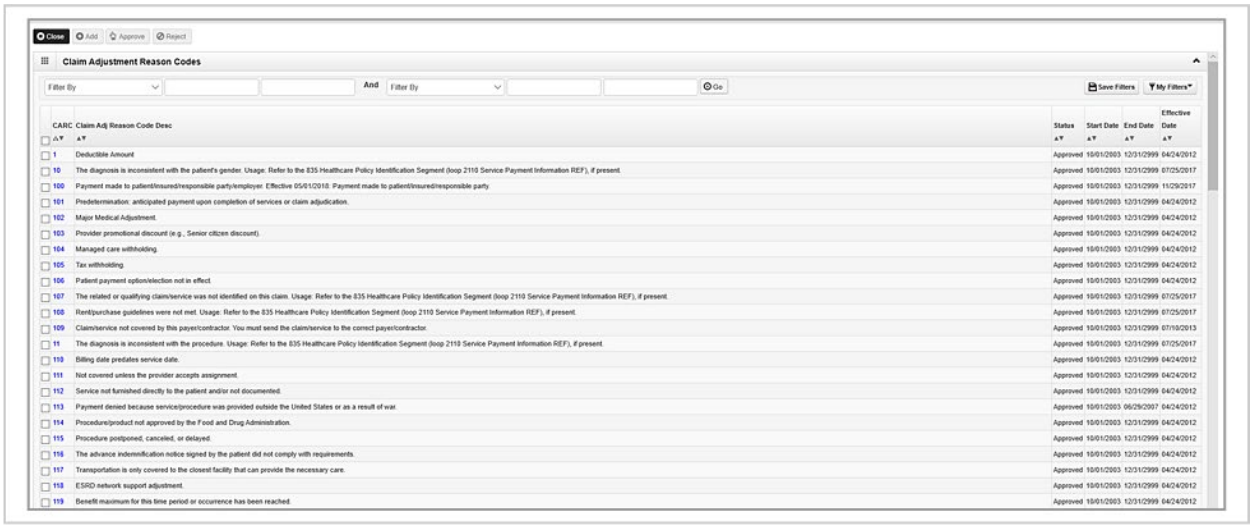
BRDM20

The Contractor solution shall store, maintain, and utilize all Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) as provided and updated by a third party.

The evoBrix X CPMS solution utilizes the industry standard EDIFECS code set files on monthly basis and maintains the changes to CARC and RARC codes. The CARC files are loaded and managed as other reference data through evoBrix X Interface Service module. Our solution allows configuration of error

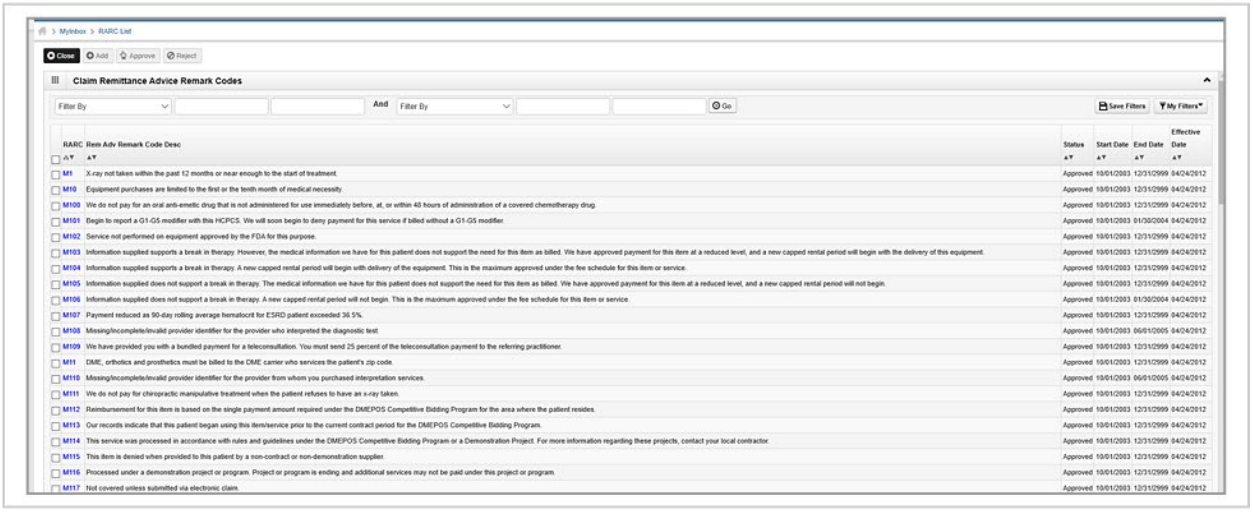
codes that are mapped to the standard CARC codes. It also ensures that each error code posted on a claim, per the validation logic and has the associated standard CMS-provided CARC codes.

The solution allows authorized users to add or update the CARC and RARC codes through online screens. It also allows configuration of error codes that are mapped to CARC and RARC. At every step of the adjudication process, business logic is executed, and any violation is captured via error codes. This error code signifies the violation of the rule and provides a description of the issues the claim encountered. Our solution then sends the adjustment reason codes and remittance remark codes on the 835 and paper remittance advice to providers explaining the adjustments and denial reasons. Figure 3.10.12-43 and Figure 3.10.12-44 show the system displaying and managing claims adjustment reason codes and remark codes.



MTCPM-1.2.4-325

Figure 3.10.12-43. Claim Adjustment Reason Codes Screen. evoBrix X Benefits and Reference Data Management module stores and maintains the CARC codes.



MTCPM-1.2.4-327

Figure 3.10.12-44. Claim Remittance Remark Codes Screen. Our evoBrix X Benefits and Reference Data Management module enables to store, maintain and utilize (report on) claims remittance remark codes as provided and updated by a third party.

BRDM21

The Contractor solution shall provide an National Correct Coding Initiative (NCCI) cost savings summary report according to CMS specifications.

The evoBrix X CPMS solution includes the functionality to produce the NCCI Cost Savings Report as specified by CMS. The data model is comprised of structures relevant to storing and maintaining claim transactions related to all procedures and edits. The evoBrix X Core Claims module also includes an extensible reporting model comprised of a standard structured set of data elements as a part of Claims Reporting that is necessary to maintain transparency into system operations. Users can leverage this model to develop ad hoc reporting that relies on the underlying data model to obtain necessary listing reports associated with NCCI Edits, as required.

BRDM22

The Contractor's solution shall provide the ability to create, view, maintain and track and list configurable covered services that may be included within benefit plans per as defined by the Agency.

Team CNSI's evoBrix X Benefits and Reference Data Management module is facilitated through a hierarchical structure and will provide the State with an online configurable functionality to define service coverage information, cost share, service limit, and funding details. Service coverage definitions can be specified at the elementary level, such as procedure code, or at a higher level, such as diagnosis code, taxonomy code, or a combination of code sets. The allowed code set categories include ICD diagnoses and procedures, HCPCS, procedure modifiers, revenue codes, bill types, places of service, provider taxonomy or specialty, claim type, revenue code and provider type.

Through online screens, authorized users will be able to make timely changes to the plan information and offer the flexibility to DPHHS to reduce or add services, define monetary limitations, or impose premium and co-pay restrictions.

Our solution comes pre-loaded with an exhaustive list of Service Types based on CAQH CORE Eligibility & Benefits Data Content Rule which can be mapped to Benefit Plans based on DPHHS requirements. These service code types can be inquired by the providers as a Generic (G) or Explicit (E) type. Any additional Service Types needed for DPHHS can be easily added to the existing list by updating the Benefit Plan Management Data store. Figure 3.10.12-45 showcases the fact that multiple applicable Service Types can be configured for any Benefit Plan.

Figure 3.10.12-46 describes how Service Types can be chosen from the available list and associated with any benefit plan.

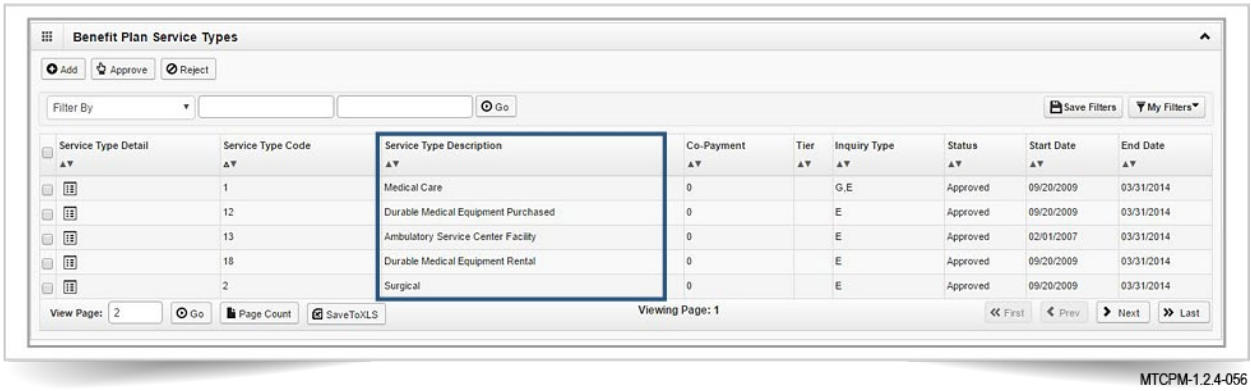


Figure 3.10.12-45. Benefit Plan Service Types Screen. The evoBrix X Benefits and Reference Data Management module captures key benefit plan service type description data and relevant information.

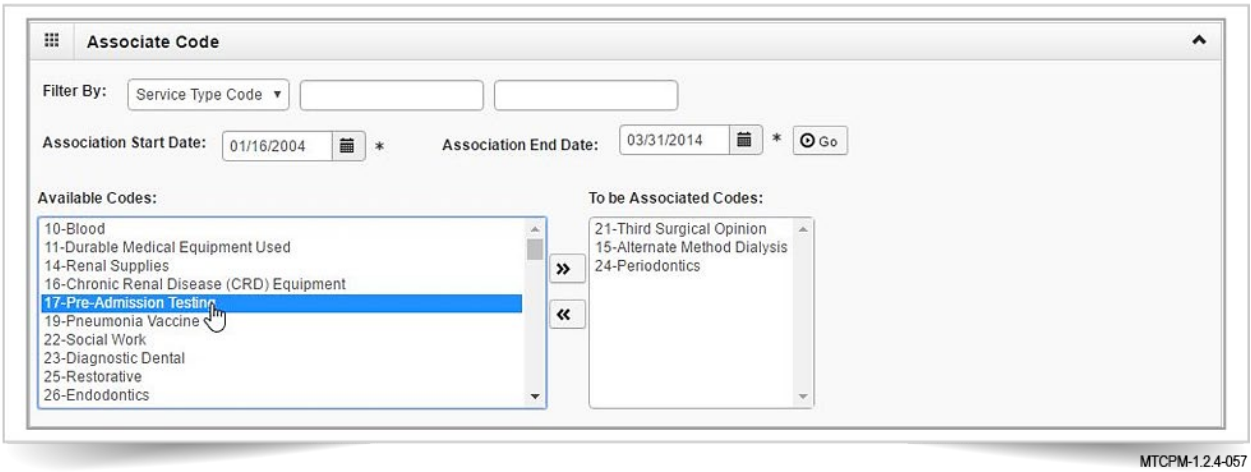


Figure 3.10.12-46. Associate Code Screen. evoBrix X Benefits and Reference Data Management module enables Service Types to be easily added to a Benefit Plan's data.

The benefit plan restrictions functionality provides the flexibility to define covered services based on code sets and service limitations defined based on claim types, provider type, place of service and/or applicable providers/specialty/sub-specialty. The service coverage definitions could be specified at the elementary level, such as procedure code, or at a higher level such as diagnosis code, taxonomy code, or a combination of code sets.

As showcased in Figures Figure 3.10.12-47 and Figure 3.10.12-48, the benefit plan restrictions configuration has the provision to include or exclude one more category of services and code set or group of entities for a Benefit Plan.

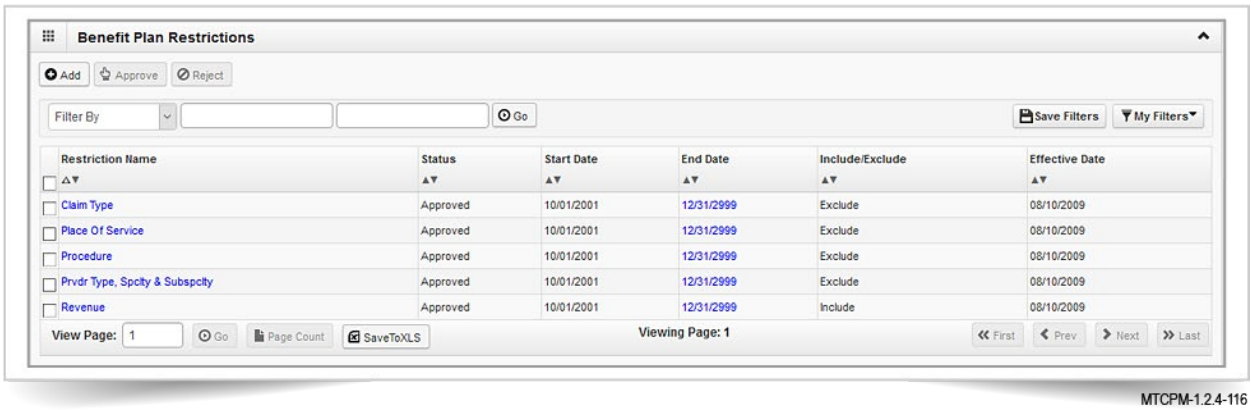
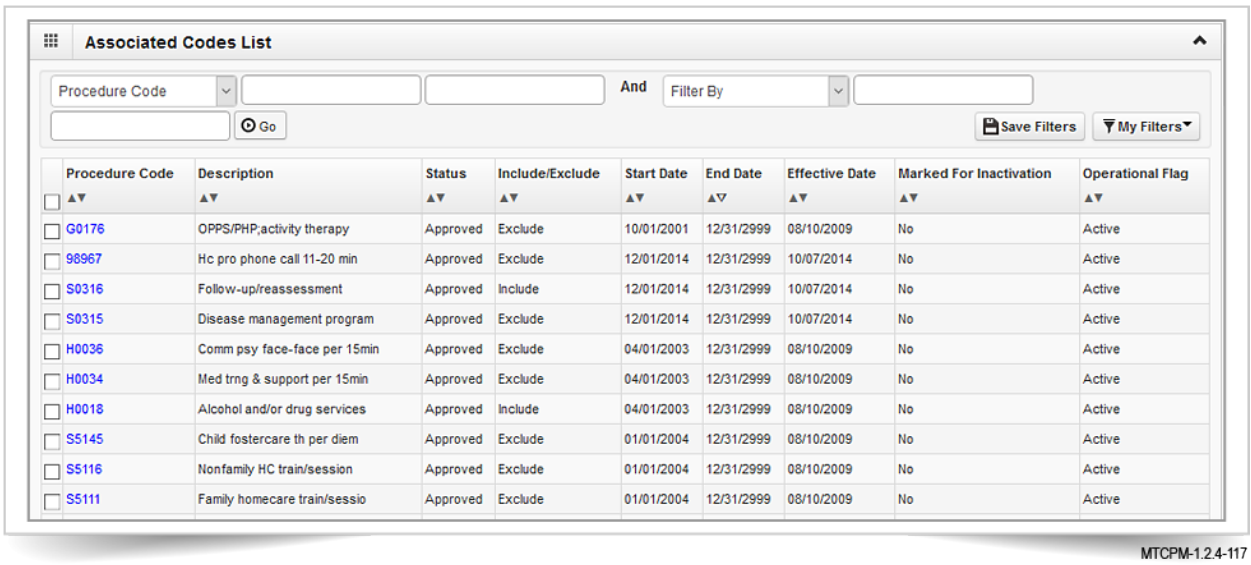


Figure 3.10.12-47. Managing Benefit Plan Restrictions. evoBrix X Benefits and Reference Data Management module displays procedure codes included/ excluded in Benefit Plan restriction as part of Benefit Plan configuration.



Procedure Code	Description	Status	Include/Exclude	Start Date	End Date	Effective Date	Marked For Inactivation	Operational Flag
G0176	OPPS/PHP;activity therapy	Approved	Exclude	10/01/2001	12/31/2999	08/10/2009	No	Active
98967	Hc pro phone call 11-20 min	Approved	Exclude	12/01/2014	12/31/2999	10/07/2014	No	Active
S0316	Follow-up/reassessment	Approved	Include	12/01/2014	12/31/2999	10/07/2014	No	Active
S0315	Disease management program	Approved	Exclude	12/01/2014	12/31/2999	10/07/2014	No	Active
H0036	Comm psy face-face per 15min	Approved	Exclude	04/01/2003	12/31/2999	08/10/2009	No	Active
H0034	Med trng & support per 15min	Approved	Exclude	04/01/2003	12/31/2999	08/10/2009	No	Active
H0018	Alcohol and/or drug services	Approved	Include	04/01/2003	12/31/2999	08/10/2009	No	Active
S5145	Child fostercare th per diem	Approved	Exclude	01/01/2004	12/31/2999	08/10/2009	No	Active
S5116	Nonfamily HC train/session	Approved	Exclude	01/01/2004	12/31/2999	08/10/2009	No	Active
S5111	Family homecare train/sessio	Approved	Exclude	01/01/2004	12/31/2999	08/10/2009	No	Active

Figure 3.10.12-48. Associated Code Listing. evoBrix X Benefits and Reference Data Management module defines procedure codes with include/exclude category under Benefit Plan Restriction.

BRDM23

The Contractor's solution shall receive and store initial and updated member eligibility code(s) and aid category and assign the member eligibility code to the corresponding benefit plan including multiple and overlapping plans, as defined by the Agency.

Team CNSI's evoBrix X CPMS solution has the capability to receive eligibility data through an DPHHS inbound interface containing member demographic information, eligibility information and member indicators/identifiers. The unique evoBrix X member match algorithm analyzes the eligibility data and assigns/updates eligibility codes and aid categories. The evoBrix X Benefits and Reference Data Management module provides the capability to create benefit plans using member eligibility attributes such as Scope, Coverage, Program, TOA, MAGI category, Recipient Aid category (RAC) and demographic information. Based on the eligibility parameter the benefit plan assignment process assigns one or more benefit plans to the member with applicable date span. The benefit plan assignment process derives benefit plans based on the member attributes and stores the information at the member level. The system also allows for defining the benefit plan hierarchy by assigning priorities to each benefit plan and is used as a tie breaker when a beneficiary would otherwise be assigned two mutually exclusive benefit plans – the plan with the highest priority is assigned and the plan with the lower priority is not. If the beneficiary ever loses eligibility for the higher priority benefit plan, the plan with the lower priority is automatically assigned. The solution will be customized based on Eligibility sources and corresponding Identifiers as defined by Agency's policy. Figure 3.10.12-49 illustrates the more than one benefit plan assigned to a member based on the eligibility parameters and that are overlapping.

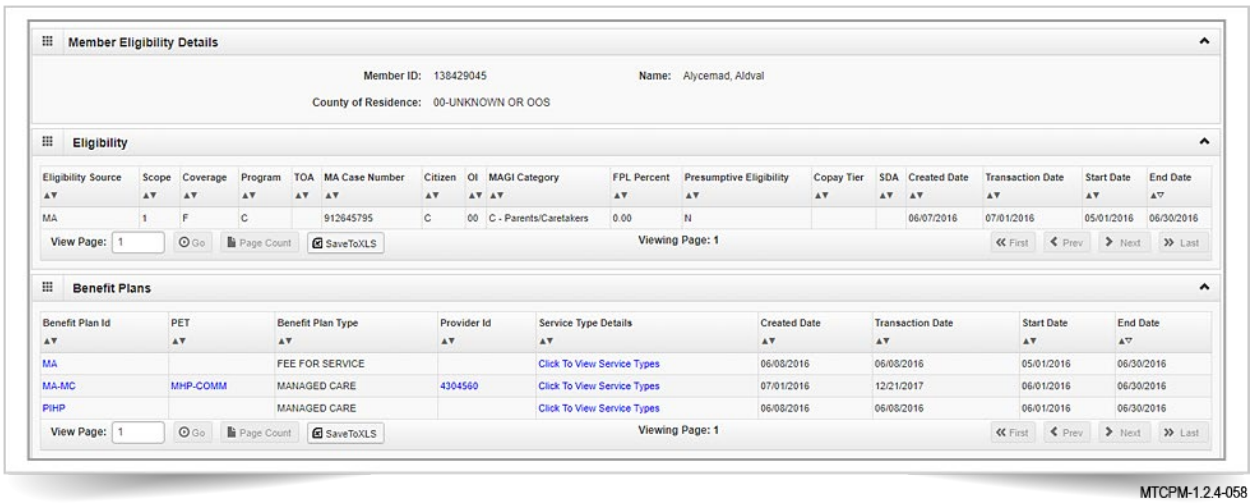


Figure 3.10.12-49. Member Eligibility Information. Team CNSI's evoBrix X Benefits and Reference Data Management module allows more than one benefit plan to be assigned to a member.

BRDM24

The Contractor's solution shall provide member lock-in based on configurable business rules (e.g., benefit plans, category of service, diagnosis, and procedure codes as defined by the agency.

Team CNSI's evoBrix X CPMS solution provides the capability to configure member lock-in restrictions based on benefit plans, providers, services, diagnosis, and program codes. The member details screen in allows authorized users to view and maintain lock-in details. The benefit plans can be configured as assigned to members based on specific program codes and to cover specific service types with define list of providers with include/exclude criteria. Figure 3.10.12-50 illustrates a member lock-in period with effective date and end date along with the pharmacy provider lock-in information.

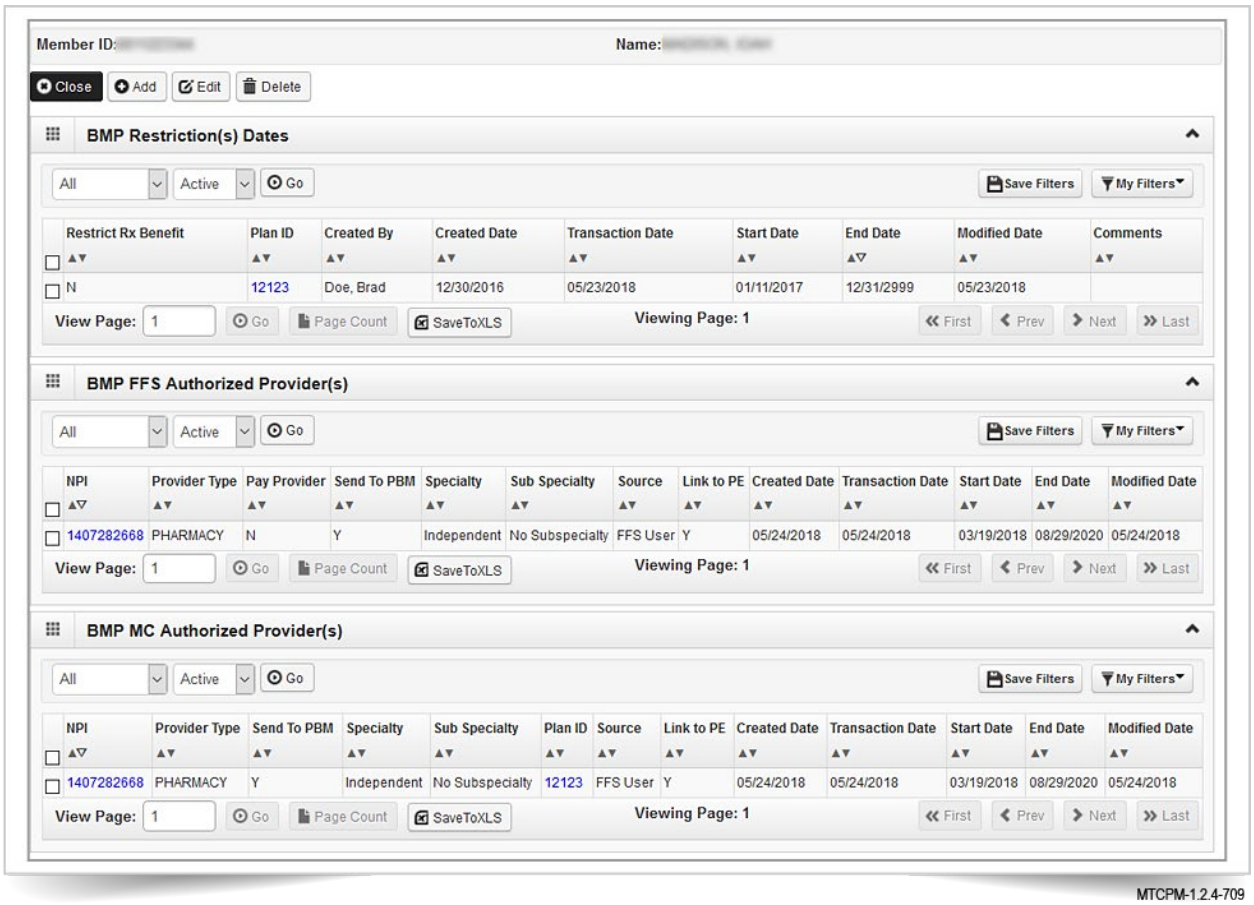


Figure 3.10.12-50. evoBrix X Benefits and Reference Data Management module provides capabilities to lock-in member to one or more providers for a defined period with effective date and end date.

Our solution provides the capability to receive lock-in information along with service details, diagnosis codes along with provider information through real time interface from various DPHHS agencies. Figure 3.10.12-51 and Figure 3.10.12-52.

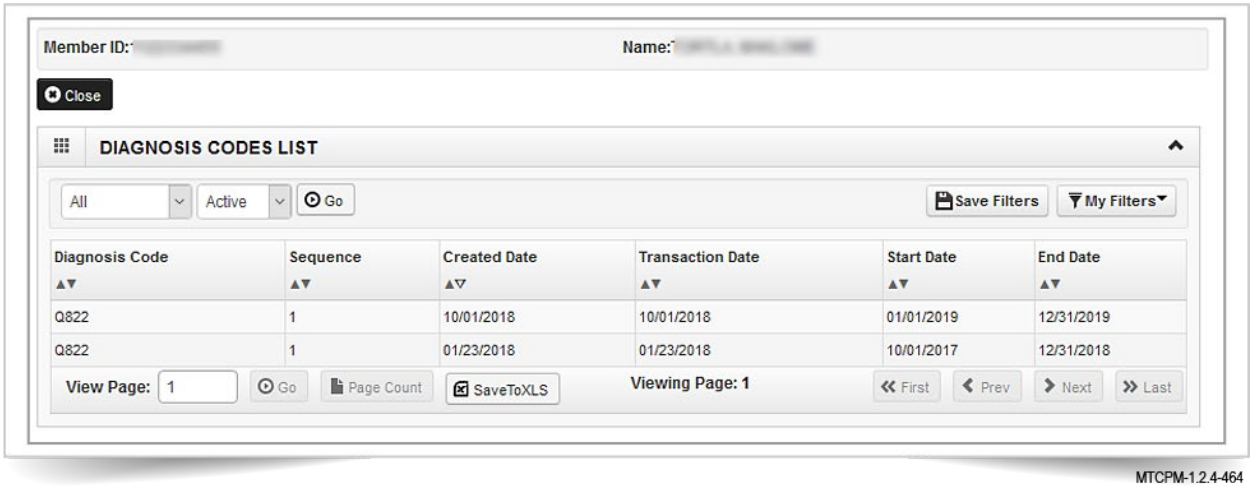


Figure 3.10.12-51. Diagnosis Codes List Screen. Our solution captures and presents diagnosis code listings and associated data for an individual Member

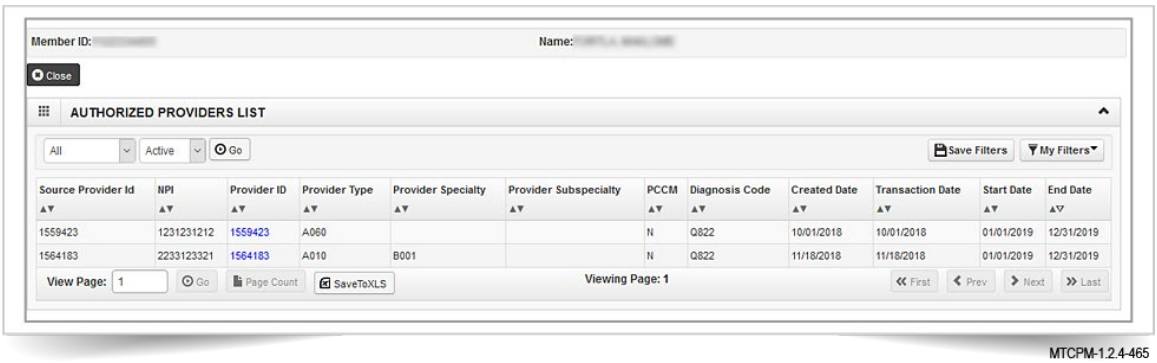


Figure 3.10.12-52. Authorized Providers List Screen. Members' provider lock-in is defined, with applicable begin and end dates.

BRDM25

The contractor's solution shall receive and store initial and updated member eligibility data and process these transactions in real-time.

The Team CNSI's evoBrix X Benefits and Reference Data Management module can receive eligibility data feeds from Agency's eligibility determination systems via batch and real-time. evoBrix X Interface module using Oracle SOA processes the web services and batch files. The eligibility data with proven Member-Match algorithm identifies the members and assigns benefit plans along with managed care enrollments. The Member-Match algorithm uses available member attributes such as First Name, Last Name, Middle Initial, Date/Month/Year of Birth, SSN, Soundex of First Name/Last Name, Member Identifiers to determine and categorize members as either New, Existing or possible duplicate. A configurable weightage is given to these member attributes to help determine the best match.

The data is loaded in a manner that maintains a history of all the changes, retaining the source information to distinguish between a batch and a real-time load. Eligibility and enrollment data are maintained at the member level within the evoBrix X Benefits and Reference Data Management module has integrated datasets, maintaining traceability between them, which allows for generation of periodic reconciliation reports. Figure 3.10.12-53 illustrate the eligibility history of a member which were loaded either via batch interface or real time webservice. The solution will be customized based on Eligibility sources and corresponding eligibility attributes as defined by Agency's policy.

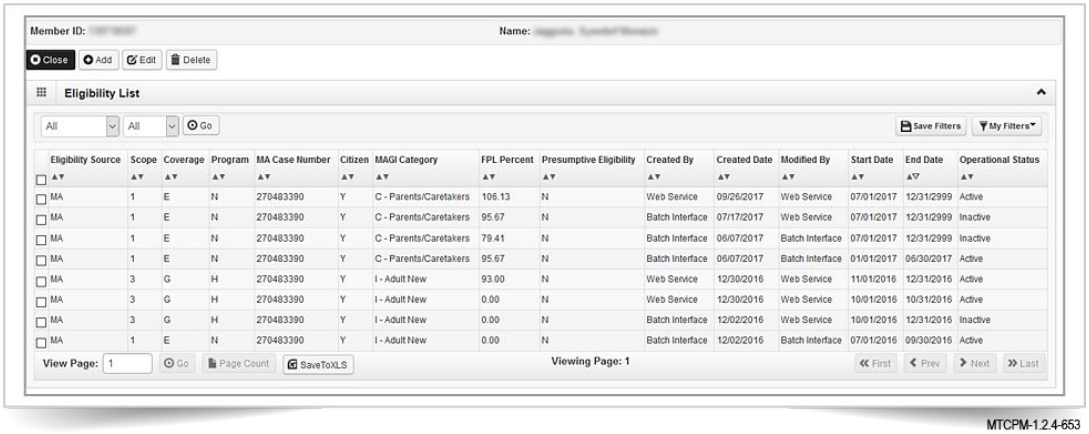


Figure 3.10.12-53. Member Eligibility History List Page. evoBrix X Benefits and Reference Data Management module stores and displays Eligibility data and maintains the history with created date, effective date, end date and created by information. The created by field helps to distinguish eligibilities loaded via either batch interface or real time web services.

BRDM26

The contractor shall monitor current and future releases of all National and Federal code sets and reimbursement methodologies and coordinate the adoption and implementation as defined by the Agency.

Team CNSI's evoBrix X CPMS solution ensures that all reference codes and reimbursement methods are pre-loaded into the evoBrix X Benefits and Reference Data Management module and checked against the National and Federal Standard code sets. Some of the major reference codes in the system include CPT-4 procedure codes, modifiers, ICD10 diagnosis and procedure codes, DRG codes, APC codes, revenue codes, HCPCS codes, revenue code/HCPCS relationships, OPPS-based rates and procedure code relationships/MUE limits per the National Correct Coding Initiative (NCCI).

Our solution accepts feeds from CMS and other approved sources on code sets, custom loads and variable rates to support the contractual agreements between the State and its partners. Code sets can be updated using the online screens and automated batch process using Interface framework.

Team CNSI business operations team will make changes to reference code sets, with appropriate testing and validation, only upon receiving authorization from DPHHS or upon mandates from CMS. Our solution also supports reference data ingestion from multiple channels and tracks reference information changes related to reimbursement methodology. Based on the agreed-upon methods and schedules in the DDI phase Team CNSI will set up the solution to update the reference data periodically.

BRDM27

The Contractor's solution shall provide the capability to clone specific data elements within a benefit plan (e.g., spans, service criteria, parameters) as defined by the Agency.

Team CNSI's evoBrix X CPMS solution provides the ability to copy the defined service types, assignment parameters, copay restriction and benefit restriction information with effective date and end date either from one benefit plan to another or within the same benefit plan using on-demand scripts. This is achieved through a service request that is defined as part of operational process and the service request will adhere to SLA timeline. This flexible approach allows DPHHS staff to request cloning the information within/multiple benefit plans. The solution will be enhanced to include a new clone feature in evoBrix X Benefits and Reference Data Management module.

BRDM28

The Contractor's solution shall store and maintain reimbursement criteria for each service according to date specific rules and limitations applicable to each claim and encounter type (e.g., service, pricing modifiers (multiple), multiple surgeries, cutbacks, benefit plan, category of service, and provider type/specialty) as defined by the Agency.

Team CNSI's evoBrix X CPMS solution stores and maintains reimbursement criteria for each service according to date specific rules. The evoBrix X Benefits and Reference Data Management module holds all the key information related to reimbursement criteria for each service for adjudicating and pricing claims and encounters, see Figure 3.10.12-54.

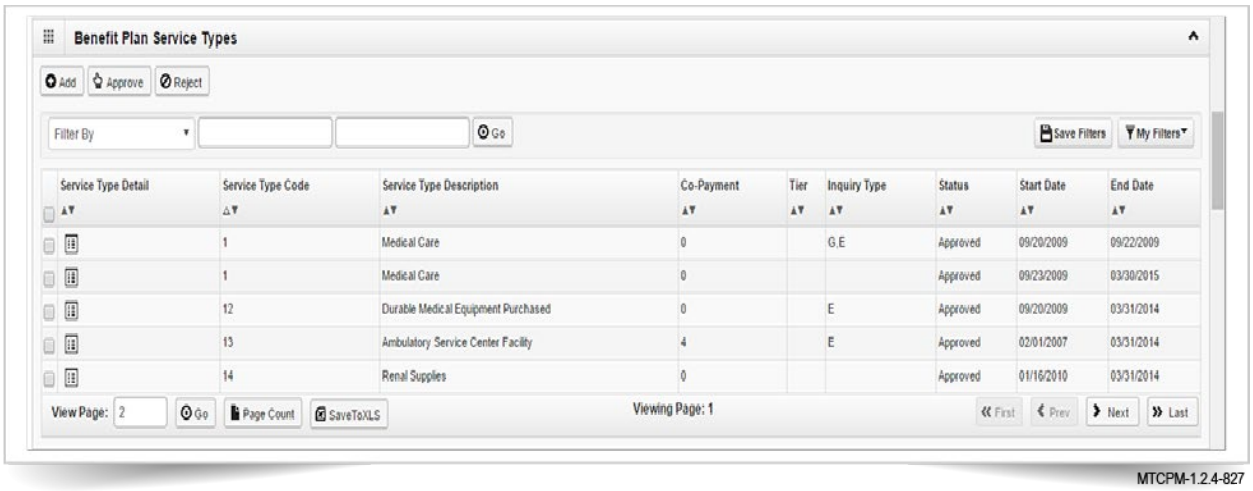


Figure 3.10.12-54. Benefit Plan Service Type Configuration. Team CNSI's evoBrix X solution can store and maintain reimbursement criteria for each service according to date specific rules and limitations applicable to each claim and encounter type.

The combination of evoBrix RuleIT engine and online configuration screens will enable authorized users to configure pricing methodologies and reimbursement criteria at claim type level. During claims processing, the evoBrix X Core Claims module will use the rules engine and the configuration data in the system to ensure all claims follow DPHHS policies and rules. The base version of evoBrix X RuleIT engine has pre-configured edits and audit related rules. These pre-configured rules will be in place for the evoBrix X Core Claims module implementation, either as is or modified as needed to satisfy DPHHS policies. evoBrix X RuleIT engine also allows for additional rules to be easily configured to comply with DPHHS policies and business rules, where necessary. Our solution will be configured to maintain and process claims using the service, pricing modifiers (multiple), multiple surgeries, cutbacks, benefit plan, category of service and provider type/specialty.

Our solution outlines the process of identifying surgeries and the rules for pricing them, pricing logic follows a hierarchy of surgery rules when more than one surgery pricing logic applies to a claim (e.g., Modifier-Based, Bilateral, Endoscopic, Multiple Surgery and Assistant Surgeon or Co-Surgeon Pricing).

Criteria for service limits and cutbacks are configurable in the benefits and administration area and can be established to cover various time periods: month, year, or lifetime. Limits, limit associations, cutbacks and conflict criteria can be defined using the Reference module, which the system utilizes during claim adjudication.

BRDM29

The Contractor's solution shall store, maintain and update reference data (e.g., edit and audit processing rules and parameters, specification of the hierarchy of edits and audits, procedures that allow pay-and-chase, supporting documentation) as defined by the Agency.

Team CNSI's evoBrix X CPMS solution meets edit and audit processing rules and parameters, specification of the hierarchy of edits and audits requirements and the system can be configured rule hierarchy as defined by DPHHS rules.

Team CNSI evoBrix X Benefits and Reference Data Management module (Figure 3.10.12-55) is capable of store, maintain and update reference data (procedures that allow pay-and-chase,

supporting documentation) as defined by DPHHS.

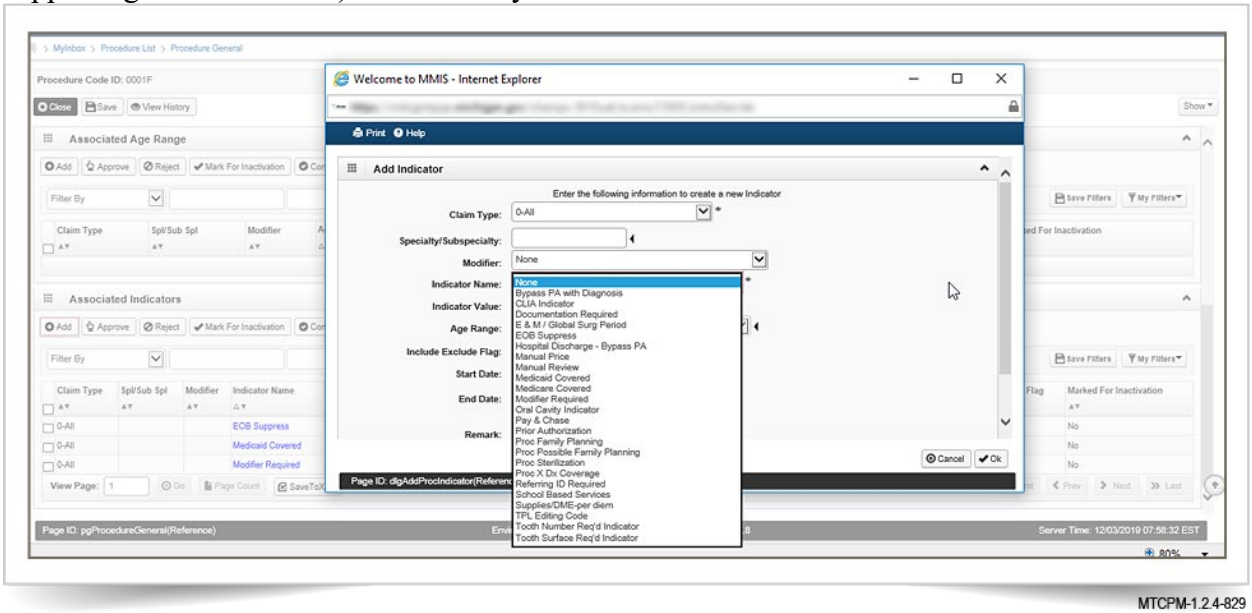


Figure 3.10.12-55. Benefits and Reference Data Management. The evoBrix X Benefits and Reference Data Management module can store,maintaing andupdateg reference data.

BRDM30

The Contractor's solution shall contain the functionality to increase or decrease reimbursement for a service based on a historical previously paid claim(s) as defined by the Agency

The evoBrix CPMS solution calculates the payment amount for each service line on the claim based on the pricing data and reimbursement methodologies that are applicable for the claim's date(s) of service. The pricing methodology applied for the claim is stamped on the claim for quick identification. Rates stored in the system and Pricing rules stored in evoBrix X RuleIT engine are date driven. All the rates stored in the system are associated with a start date and end date along with effective date. This provides the flexibility to adjust historical previous paid claim with the updated rates and pricing rules. This feature enables the State to create the adjustments (increase or decrease reimbursements) through evoBrix X Core Claims module's mass adjustments, manual adjustment and provider adjustment processes.

The solution can send notification and alerts when there is update in claim pricing, pricing updates and statistical variances identified on reporting of weekly operational report. Impacted claims are grouped and routed to appropriate units for rework and making required payment changes which is handled as part of manual pricing using resolve screen or using mass adjustment functionality the high volume of impacted claims is reprocessed in single instance.

BRDM31

The Contractor's solution shall provide the capability to clone a claim in a test environment to modify specific data fields (e.g., reimbursement methodology, procedure code) and adjudicate the claim.

Team CNSI's evoBrix X CPMS solution provides the capability to create and maintain specific claim templates that is built to remove the labor-intensive task of re-entering the same data on similar claims. The claim templates can be leveraged during testing to clone a claim or modify specific data fields such as procedure, diagnosis, revenue, surgical and other data fields to meet the test scenario as shown in Figure 3.10.12-56. The saved claim templates can be searched, as shown in Figure 3.10.12-57, using

various options. The Search Template feature allows users to get the most appropriate template to speed up the data entry work. Team CNSI operations team will also support to load the same HIPAA file or paper claim or DDE claim from the Production environment to test environment. This will help Agency to have the same data set from Production environment. In the test environment users can modify the data and make the claim go through the adjudication process and view the results.

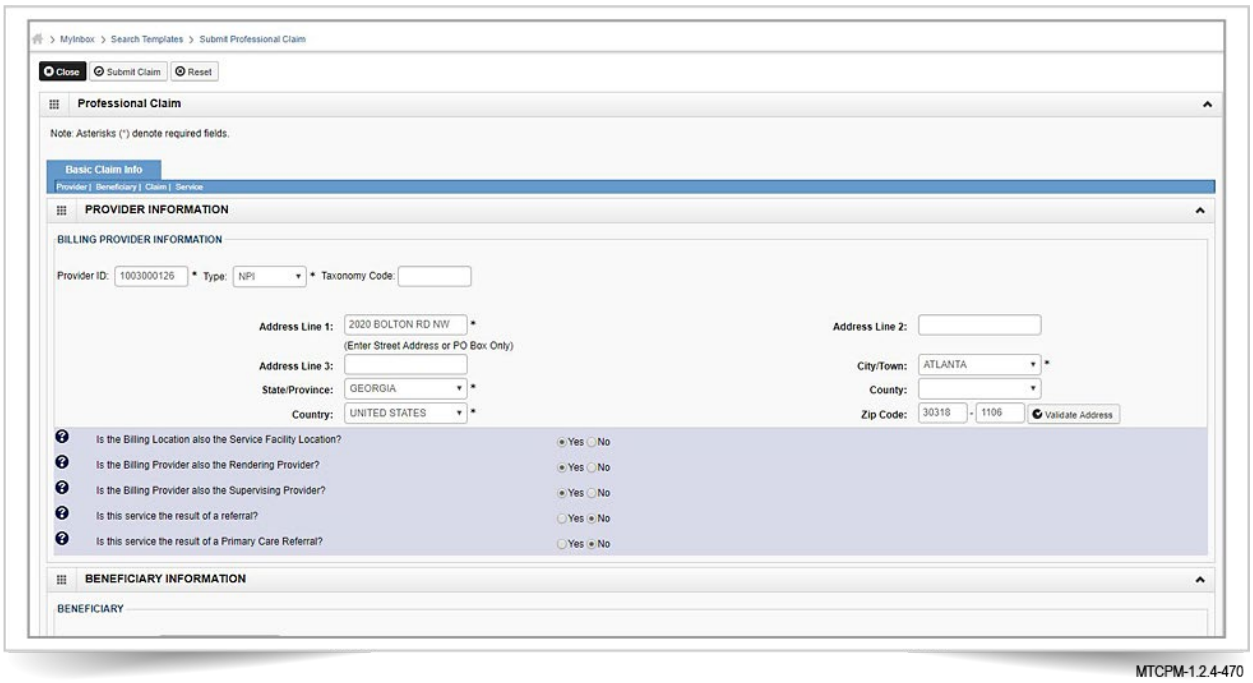


Figure 3.10.12-56. Submit Claims using Templates. When a template is selected to enter a claim, the screen above is displayed.

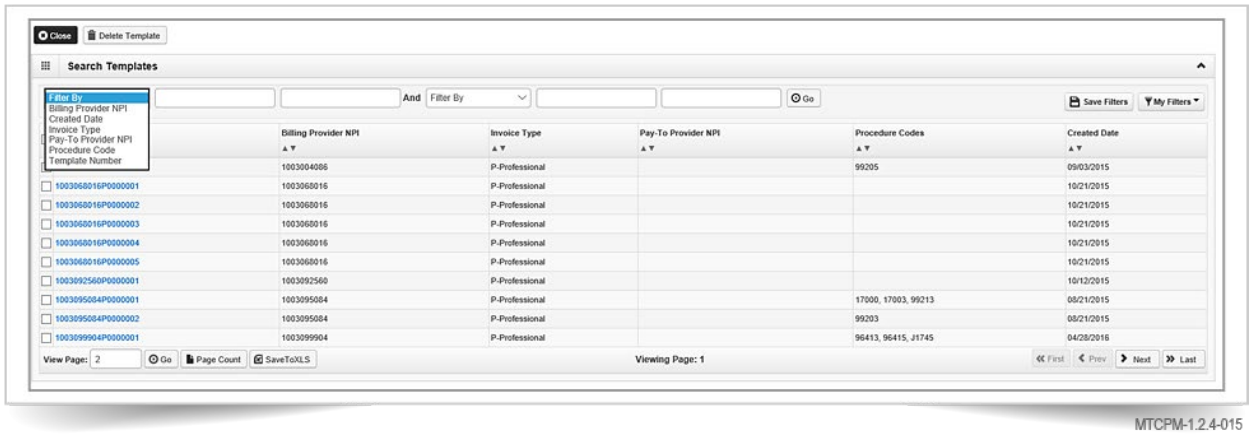


Figure 3.10.12-57. Search Templates. Saved templates help providers and claims staff to quickly select an appropriate template to enter a claim.

BRDM32

The Contractor's solution shall automatically update Insurance plan information on individual records when the carrier plan is changed as defined by the Agency.

Team CNSI's evoBrix X Third Party Liability (TPL) management module provides robust features to receive, load and update insurance plan information either via batch interface or real time webservice. A

new insurance plan information will be created or existing will be modified for a member based on changes to the following information:

- Insurance Carrier
- Insurance Type
- Coverage Type
- Coverage Span
- Policy Number
- Group Number
- Primary Policy Holder

Figure 3.10.12-58 illustrates an update to an insurance plan information through interface process. The insurance plan can be updated either through a batch process, a real time process or manual update by an authorized DPHHS staff. The solution will be customized to accommodate multiple Agency approved TPL sources.

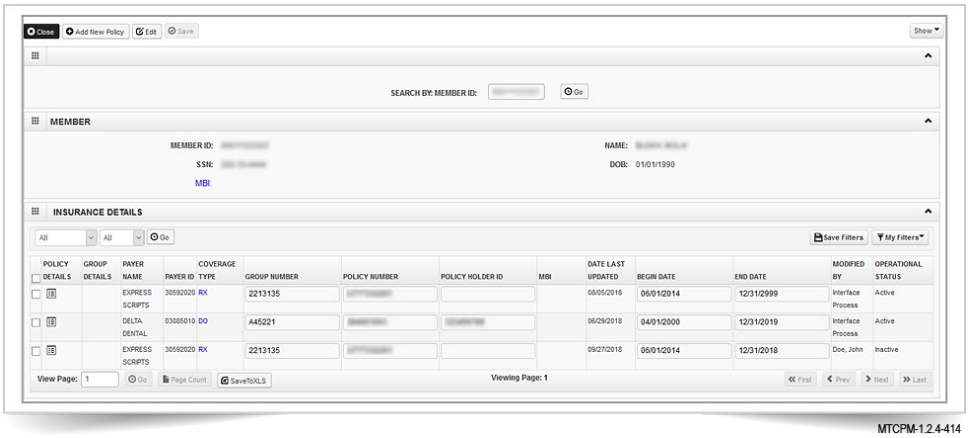


Figure 3.10.12-58. Screenshot of Member Policy Information. Our solutions can update this information through in an automated interface batch process.

BRDM33

The Contractor's solution shall generate a configurable Explanation of Benefits (EOB) for each member or a selected group of members based on configurable criteria defined by the Agency.

Team CNSI's evoBrix X CPMS solution has capabilities to stamp all the edits/audits posted on the claim at header as well as line level. A batch process with configurable member selection runs automatically after the RA process to map each edit to a HIPAA-compliant Explanation of Benefits (EOB). If a claim has a cutback or denial, the corresponding EOB will be reflected in the process. Team CNSI's correspondence framework will be leveraged to generate the EOBs.

Our solution allows authorized users to define EOB Suppress Indicator at code set level (HCPCS/Revenue Codes, Diagnosis Codes, and Surgical Procedure Codes). The indicator will be set to 'Y' for claims that will be suppressed, and therefore not printed onto the EOB correspondence. Authorized members will access their EOBs using evoBrix X Member Poral.

Team CNSI will collaborate with the State to elicit, analyze, and document additional business rules and policies to create configuration data for the purposed listed below:

- To produce EOBs for program participants and based on criteria developed and maintained by the State
- To generate EOBs on demand as requested by authorized State users

- To allow the suppression of the production of EOBs or specific data on the EOB based on member and service characteristics as defined by the State
- To track the results of the EOB responses and make the results available online or via report format to authorized users
- To integrate with other systems such as Member Portal to display the EOBs

3.10.13 Claims Data and Reporting

This section addresses requirements related to collecting, maintaining, and reporting claims data. The Contractor's solution shall provide an established library of standardized operational reports. The solution will include sophisticated configurable automated and ad-hoc reporting functionality based on current and historical medical and non-medical transaction data including claims (paid, pending, and denied), rate updates, and provider payment. These reports and analyses will be used to inform State and Federal reporting and support the information requirements necessary for the evaluation, comparison, and management of claims. The Offeror must describe in detail their approach to meet each of the Claims Data and Reporting requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Data is the most valuable resource of any Medicaid enterprise and, as such, the timely availability of that data is critical to the overall success of the MT CPMS project. Reliable and secure access to enterprise data enables Team CNSI's operations staff and the Department of Public Health and Human Services (DPHHS) to make data-driven decisions that favorably impact operations on a daily basis, starting from Day One of the project and lasting over the life of the Contract.

The Team CNSI Advantage

The evoBrix X platform includes robust, configurable reporting with integrated analytics capabilities to enable stakeholders to quickly generate reports and leverage the information to improve business outcomes.

- Web-based IBM Cognos business intelligence suite provides the flexibility to incorporate changes in a quick time frame
- Scalable data architecture for evoBrix X online system
- More than 170 out-of-the-box reports to support most state reporting needs
- Flexible ad hoc reporting feature enables stakeholders to design custom reports
- Identity management and security: end users will be able to conduct single sign on (SSO) to seamlessly navigate from evoBrix X to IBM Cognos BI
- HealthBeat dashboard provides near real-time visualization of operational data

MTCPM-1.2.4-005

A solution framework must facilitate data access and management needs of a diverse group of users without compromising the data manageability and security within the Medicaid enterprise. Continuous and reliable reporting enable DPHHS and Team CNSI to collect, maintain, track, and report all MPATH Program information, activities, and trends. The evoBrix X Core Claims module's reporting capabilities include extensive features that offer a comprehensive view into day-to-day business operations as well as system activity. Our solution turns every piece of data into useful and actionable information.

Business operations reporting focuses on information needed by authorized users for business administration and management roles and responsibilities which include:

- Claims and encounter data tracking
- Benefits and Management data tracking
- Eligibility and Enrollment data tracking
- Prior Authorization data tracking
- Third party liability (TPL) data reporting
- Managed Care data tracking
- Ad-hoc reports from an operational perspective
- Volumes and ages of claims inventory
- Financials Reports

In addition, we focus systems reporting on:

- Service level agreement (SLA) compliance
- Transaction logging
- Audit tracking

Team CNSI built the evoBrix X reporting framework on a scalable data architecture and business process management layer to ensure data integrity and accurate, consistent reporting. Our evoBrix X reporting

and analytics architecture, as shown in Figure 3.10.13-1, supports the business needs for successful MPATH operations by providing the following:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

[redacted]

Figure 3.10.13-2 describes the salient features and benefits of our reporting and analytics solution.

Features	Benefits
Granular data access	We provide Medicaid-specific, detailed data that are not available in typical off-the-shelf solutions. Team CNSI uses this data for ad hoc reporting and analysis purposes.
Self-service BI Reporting	We deliver user satisfaction and productivity gains reports to end users over the Internet. Users can print/save reports as needed.
Ad Hoc Reporting	We provide DHPPS users with access to aggregated data with different dimensions as well as underlying detailed data needed to support critical activities (e.g., reconciliation and policy making).
Prebuilt Reports/Templates	We offer increased productivity through pre-built operational reports and templates.
Single Sign On	We ensure a reduced risk of account compromise with single sign on functionality within our solution and IBM Cognos BI, without replicating user credentials across multiple directory stores.
Operational reporting	We provide powerful payment cycle information, business SLA compliance alerts, worker productivity, and business operations summaries as part of our comprehensive operational reporting.

Figure 3.10.13-2. Features and benefits of our reporting and analytics solution. Team CNSI's approach addresses the State's various reporting requirements.

Team CNSI offers an established library of standardized operational reports. We provide a list of more than 170 pre-defined reports within the evoBrix X Core Claims module in Figure 3.10.13-3.

Report ID	Report Name	Report Description
BA_001	Anesthesia Fee Schedule	This report publishes an anesthesia-specific database to providers/other users.
BA_002	Benefit Plan Assignment and Priority Master (BPA&PM)	The BPA&PM Report defines the characteristics of each benefit plan supported by the BPA&PM (Access Program Report) Legacy Report.
BA_003	Clinical Lab Fee Schedule	This report provides code information for providers/other users.
BA_004	Dental Fee Schedule	This report provides dental code information for providers/other users.
BA_005	DRG Relative Weight	This report provides information on diagnosis-related group (DRG) weight, which is the average standardized costs for cases assigned to a DRG divided by the average standardized costs for cases assigned to all DRGs.
BA_006	Generic Fee Schedule	This report provides code information for providers/other users.
BA_007	Generic Relative Value Unit (RVU) Based Fee Schedule	This report provides code information for providers/other users.
BA_008	Physicians Practitioners and Medical Clinics Fee Schedule	This report provides physician/practitioners and medical fee schedules.
BA_009	Practitioner and Medical Clinic Database Report	This report provides practitioner and medical clinic transactional data.
BA_010	Procedure Code In-Review Records	This report provides a list of all the "in-review" records at the code detail level and for those associated to age and indicators.
BA_011	Provider DRG Rate Factors	This report provides information on provider Diagnosis Related Group (DRG) rate factors.
BA_012	Quarterly MUE	This report compares medically unlikely edit (MUE) data between

Report ID	Report Name	Report Description
	Comparison	the current quarter and the prior quarter.
BA_013	RVU Load Comparison	This report compares RVU data between the current quarter and data currently loaded into our solution in all fields and shows only the ones that differ.
CLM_001	Account Code Failure	This report lists all the claims that failed account code allocation.
CLM_002	835 Summary	This report is generated as part of claims remittance advice (RA) process to show count of Data Exchange Gateway (DEG), National Provider Identifier (NPI), and Tax IDs.
CLM_003	Adjudicated Claims Throughput Analysis	This report displays the average number of days it takes our solution to process claims submitted by a provider group.
CLM_004	Beneficiary Paid Claims	This report displays paid claims for a beneficiary for a specified period.
CLM_005	Cash Report By Tax ID	This report lists the NPI cash breakouts for any given Tax ID and for the selected pay cycle.
CLM_006	Claim Printout Dental	This report provides full details related to an individual dental claim.
CLM_007	Claim Printout Institutional	This report provides full details related to an individual institutional claim.
CLM_008	Claim Printout Professional	This report provides full details related to an individual professional claim.
CLM_009	Claims Stuck in Processing	This report displays claims loaded into our solution that have been stuck in one status for more than a specified number of days or are unable to process to a RA.
CLM_010	Current Aging Suspended Statistics	This report outlines aged suspended claims by invoice type. It summarizes aged claims by days on file. It also summarizes claims by Replacements and Voids.
CLM_011	Daily Control Report - Paper	This report provides a listing of all daily paper batches.
CLM_012	Daily Inbound Control - Electronic	This report summarizes all daily claim transaction files (FFS, encounters, 270, 276, 278 and zero-byte files).
CLM_013	Daily Outbound Control - Electronic	This report summarizes all daily HIPAA claim transactions.
CLM_014	Error Code Count - Daily	This report identifies the transaction control numbers (TCNs) that errored (and were not included) in the mass upload batch.
CLM_015	GA Inbound	This report displays error records from gross adjustment interface files.
CLM_016	GA Outbound	This report displays error records from gross adjustment interface files.
CLM_017	Gross Adjustments Approved/Not Paid	This report displays approved gross adjustments that were not paid during the current pay cycle versus previous pay cycles by gross adjustment code.
CLM_018	Approved GA	This report displays the list of gross adjustments that were approved between the selected start and end date.
CLM_019	Mass Adjustment Error	This report identifies the TCNs that errored (and were not included) in the mass upload batch.
CLM_020	Monitor Override Error Codes by Worker	This report summarizes the number of override error codes by a worker.
CLM_021	NCPDP Batch Submission Results	This report shows the receipt and processing of National Council for Prescription Drug Programs (NCPDP) batch files.
CLM_022	Operational Performance	This report displays statistics of claims status changes for: a

Report ID	Report Name	Report Description
	Summary	selected payment cycle; the same pay cycle and previous three pay cycles; the same four pay cycles for the previous year; the average of the last 26 pay cycles; and year-to-date fiscal year for both the current year and the previous year.
CLM_026	Prompt Payment	This report shows the compliance percentage of claim payments.
CLM_027	Prompt Payment Report - 30 Days	This report shows the compliance percentage of claim payments for the last 30 days.
CLM_028	Suspended Claims by Worker	This report displays claims that have been suspended for a specific number of days. Users enter the range and use the claim's TCN date to select the TCN-calculated age range for the report.
CLM_029	Suspended Claims Report	This report displays information on the edits that are set on claims that are suspending in our solution, as of a point in time.
CLM_030	Worker Productivity	This report displays worker productivity (count of claims worked) for each day of the week.
CLM_031	Average Approved Amount per Claim By Pay Cycle	This report displays a line chart for ICD9 and ICD10 Average Approved Amount per Claim for pay cycle versus ICD9 and Average Approved Amount per Claim for average 26 pay cycles comparison.
CLM_032	Average Days from Date of Service to Date of Payment Trend	This report displays (ICD9+ICD10) average days from date of service to date of payment as line and ICD9 and ICD10 as a cluster is created by pay cycle for all provider types.
CLM_033	Average Days from Date of Service to TCN Date Trend	This report displays (ICD9+ICD10) average days from date of service to TCN date as line and ICD9 and ICD10 as cluster lines and created by pay cycle for "All" provider types.
CLM_034	Average Days from TCN Date to Date of Payment Trend	This report displays (ICD9+ICD10) average days from TCN date to date of payment as line and ICD9 and ICD10 as cluster lines are created by pay cycle for all provider types.
CLM_035	Percent of Amount Approved per Amount Billed per Claim	This report displays a line chart for ICD9 and ICD10 Percent of Amount Approved per Amount Billed per Claim for pay cycle versus ICD9 and ICD10 Percent of Amount Approved per Amount Billed per Claim for average 26 pay cycles comparison.
CLM_036	Total Amount Approved Trend	This report displays a stack bar chart with ICD9 and ICD10 total approved amount created based on the time horizon and provider types "All."
CLM_037	Total Claims Processed Trend	This report shows the trending for total claims paid/denied/suspended for All (ICD9+ICD10) claims by pay cycle.
CLM_038	Total New Claims Processed Trend	This report shows the trending for new claims paid/denied/suspended for All (ICD9+ICD10) claims for the time horizon.
CLM_039	Error Code Disposition	This report lists all the edit disposition changes applied in our solution during the prior quarter.
CLM_040	Encounter Batch Submission Results	This report displays details about file status (e.g., file load date, translation date, etc.)
CLM_041	Encounter Errors Posted by Submitter	This report displays details about file status (e.g., file load date, translation date, etc.)
CLM_042	Encounters Stuck in Processing	This report displays information on batches that include encounters that failed during edits processing.
CLM_043	Prompt Payment Report History	This report shows the compliance percentage of claim payments for a specified period.

Report ID	Report Name	Report Description
CLM_044	Total Claims Processed ICD9 vs ICD10 Trend	This report shows the trending for total claims paid/denied/suspended for ICD9 and ICD10 claims by pay cycle.
CLM_045	Total New Claims Processed ICD9 vs ICD10 Trend	This report shows the trending for new claims paid/denied/suspended for ICD9 and ICD10 claims for a specified period.
CLM_046	ICD9 vs ICD10 Claims Summary	This scheduled report, which is also available on-demand, includes ICD9, ICD10, and ICD9+ICD10 (All) summaries for total new claims processed and total amount approved for new claims processed, which can be grouped by Invoice Type, Claim Source, or Claim type.
CLM_047	ICD9 vs ICD10 Performance Metrics Detail	This report breaks up the ICD9 vs. ICD10 performance metrics for all provider groups by a given metric. The average of the last 26 pay cycles for each of the metrics is also available side by side for easy comparison
CLM_048	ICD9 vs ICD10 Performance Metrics Summary	This report summarizes key ICD9 vs ICD10 performance metrics for a given pay cycle. The average of the last 26 pay cycles for each of the metrics is also available side by side for easy comparison.
EE_001	834 Control and Error Detail	This report provides statistical totals related to the preparation of records for HIPAA 834 files. The report is organized by Program and Roster type. The bottom of the report includes detailed error messages by Program and Roster type.
EE_002	Benefits Monitoring Review	This scheduled monthly report indicates beneficiaries with a benefits segment with an end date greater than two years from the current date.
EE_003	LOC Segment Error	This report lists errors encountered if multiple Level of Care segments are present in a benefit plan.
EE_004	Daily 4948 Card Issuance File Control	This is a control report for outbound ID card file.
EE_005	Daily 4949 Vendor Card Audit File Control	This report summarizes the records included in the 4949 Vendor Card Audit file and applied to our solution.
EE_006	Eligibility Update Control	This report provides totals of records received from transaction sources. For each source, totals are broken out by new/existing/rejected records as well as updated/unchanged records. Total fatal errors by source are reported as rejected records. Total non-fatal errors by source are reported as error records. Total card issuance records are calculated as the sum of new eligibility records and CRM source transactions, which represent card replacement requests.
EE_007	Eligibility Verification	This report shows counts of detailed information captured from both batch and online eligibility verification transactions.
EE_008	Managed Care Medicaid Expansion Population Report	This report summarizes enrollment statistics by level-of-care within each County code for Medicaid Expansion program
EE_009	Integrated Care Organization Managed Care Population	This report summarizes enrollment statistics by level-of-care within each County code.
EE_010	IRS 1095-B Error	This report shows a list of all the errors found by the IRS to be corrected by Team CNSI members.
EE_011	Managed Care Population	This report summarizes enrollment statistics by level-of-care within each County code.
EE_012	Medicare Birthday Letter	This report summarizes the number of Medicaid Birthday Letters

Report ID	Report Name	Report Description
	Control	that are generated.
EE_013	Member Level Error	This report indicates errors encountered when processing eligibility updates from source systems. The report is sorted by Transaction Source, DPHHS, County, and District (when source = MA), RID/CIN, Fatal Errors, and Warning Errors. For fatal errors due to detection of a duplicate members, the report provides the Duplicate Matched ID. The report also covers interface validation errors.
EE_014	Newborn Match Control	This report summarized the results of the newborn match process.
EE_015	Number of Enrollees Assigned to a PCP	This report displays the number of enrollees assigned to a primary care provider (PCP), including the total number assigned to the provider for each managed care organization (MCO) and the total number of enrollees assigned for all MCOs in which the provider is participating.
EE_016	Pre-Validation Error	This report lists beneficiary's information where information does not meet federal IRS requirements.
EE_017	Total Enrollees by County	This report shows the total enrollees by County and includes the number of plans per County with a breakout of enrolled members, unenrolled mandatory members, and percent enrolled.
EE_018	Total Enrollees by Enrollment Source	This report provides a list of total number of enrollees broken out by how their enrollments were submitted (for instance, via paper, phone call, enrollment portal).
EE_019	Total Enrollees by Gender, Age and Program	This report provides the total number of enrollees broken out by gender, age, and program (using the program code in the eligibility segment).
EE_020	Total Enrollees by Plan and County	This report lists enrollees by County and the number of plans per County with a breakout of enrollee members, unenrolled mandatory members, and percent enrolled.
EE_021	Total Enrollee Count by Plan by County with Previous Month Comparison	This report provides the enrollee count by plan within a County, and the previous month's count for a comparison.
EE_022	Total Health Plan Enrollees by Month/Year	This report provides the total number of health plan enrollees by month/year.
EE_023	Total Health Plan Enrollees by Month Year with Month to Month Difference Count Compare	This report provides the total number of health plan enrollees by month/year with a month-to-month difference count compare.
EE_024	Total Member Count by Reason for Mandatory, Excluded and Voluntary	This report provides total number of members who fall into the mandatory, excluded, and voluntary buckets, with a breakout by reasons (for both excluded and voluntary) and County.
EE_025	Total New Enrollees by Health Plan by Enrollment and Re-Enrollment	This report lists new enrollees (broken out between those not enrolled in a plan within 60 days and those who have never been in a plan) and enrollees that were re-enrolled into a plan within 60 days.
EE_026	Total Number of Counties by Percentage of Health Plan Enrolled by Month/Year with Month	This report captures the number of Counties based on the percent enrolled into health plans by comparing total enrolled (mandatory, voluntary, and excluded) for the report month vs. total unenrolled (mandatory). The comparison is based on total mandatory, total voluntary, or total excluded enrolled in a health plan vs. total un-enrolled (mandatory) for the report month.
EE_027	Total Out of Service Area Enrollee Counts by Plan	This report provides the total out of service enrollee counts by plan by month.

Report ID	Report Name	Report Description
EE_028	Total Mandatory Unenrolled Members by Month/Year with Month to Month Difference Count Compare	This report provides the total number of mandatory unenrolled members population by month/year with a month-to-month difference count compare.
PA_001	Analyst Verbal	This is an ad hoc report to be run for a specified decision maker.
PA_002	Audit Report by Provider/Procedure Code	This report shows all procedure codes and all beneficiaries within a selected provider.
PA_003	Audit Report By Tracking Number	This report shows the tracking changes/modifications made for the field for a given tracking number.
PA_004	Beneficiaries Served Benefit Plan	Multiple report pages list the distinct program, Beneficiary ID, and beneficiary name for each beneficiary that had a prior authorization (PA) during a time span specified by a user. This report summarizes the count of beneficiaries served by each program.
PA_005	Beneficiaries Served Benefit Plan Benefit Plan	These reports show claims information for a provider over a selected period. It identifies any claims returned that were prior authorized. If a claim is prior authorized, the report displays the Prior Authorized Date of Service and the Prior Authorized Benefit Plan.
PA_006 PA_007	Beneficiaries Served Benefit Plan Benefit Plan Brain Injury Waiver Authorized Expenditures	These reports show claims information for a provider over a selected period. It identifies any claims returned that were prior authorized. If a claim is prior authorized, it displays the Prior Authorized Date of Service and the Prior Authorized Benefit Plan.
PA_008	Case Review Data Check	This report compares data between the Financial Report (Inpatient or Special Services) and the corresponding (Inpatient or Special Services) Prior Authorization Certification Review Summary Report.
PA_009	Medical Health Enrollment Age Out	This report shows those individuals receiving a Private Duty Nursing (PDN) service (S9123 or S9124) who will turn 21 during the fiscal year (or within a specified date range). This is for all people under age 21 receiving a PDN.
PA_010 PA_011	Medical Health Enrollment Durable Medical Equipment (DME) Review Summary	This report lists enrollees in either the HSW under age 21 or the children's waivers who get services prior authorized (approved).
PA_010 PA_011 PA_012	Medical Health Enrollment DME Review Summary Medicaid Financial - Detail	These reports detail the number of reviews completed by a Review Contactor (RC) within the report date range and a broad breakdown of the outcomes. This also shows the same things for the PR reviews. The Medicaid Financial Detail report shows the number of cases reviewed with a billable authorization status for each beneficiary in the Prior Authorization Certification Review program.
PA_013	Medicaid Financial Report - Summary	This report summarizes the dollar amount to be received from the State.
PA_014	Modify Prior Authorization Request in Batch Verification Control	This report is automatically produced as a by-product of executing the Modify PA Requests in Batch Verification process.
PA_015	Prior Authorization Certification Review Summary	This is an inpatient hospitalization review summary report.
PA_016	Physician Review	This report details the number of reviews for a physician.

Report ID	Report Name	Report Description
	Statistics	
PA_017	Case Review Internal Monitoring	This report displays all the cases in the month selected that are Approved, Denied, or labeled No Action by different decision makers.
PA_018	PRD Activity with Benefit Plan Line Count	This report displays PA requests and beneficiary counts by organization unit for the period designated by a user.
PA_019	PRD Activity with Benefit Plan PA Count	This report shows PA requests and beneficiary counts by organization unit for the period designated by a user.
PA_020	Review Contractor (RC) Internal Monitoring	This report lists cases that have been completed that month by each RC and each PR. The columns displayed are Beneficiary ID, Decision Complete Date, Service Type and Referred. The manager can look up these cases and review to see if the reviewer did an appropriate review.
PA_021	Case Review Statistics	This report details the Prior Authorization Certification reviews performed by a Review Coordinator.
PA_022	Specific Program Activity	This is an ad hoc report for a specified service type.
PA_023	SQL-Based Medicaid Financial - Detail	This report shows the number of cases reviewed with a billable authorization status for each beneficiary in the Prior Authorization Certification Review program.
PA_024	Timeliness Statistics - Medical Review	This report details reviews by RC and Physician Reviewer by timeframe.
PA_025	Timeliness Statistics - Telephonic Reconsideration	This report details the number of telephonic reviews completed in various timeframes.
PA_026	Tracking Report By Analyst	This is a weekly tracking report for all analysts, preferably generated every Wednesday.
PA_027	Logged Off By	This report displays the list of PAs logged off by a user.
PA_028	Logged On By	This report displays the number of PAs logged on by a user
TPL_001	TPL Case Worker	This report identifies the processing time to close each lead by each TPL lead worker.
TPL_002	Open SRs More than 5 days with TPL	This report is required for TPL to find Service Requests (SR)s that are in open status for more than five days.
TPL_003	Coverage Match Summary	This report shows the summary results of the coverage match process by Payer ID and Information Source. A single member can have multiple coverages on the file. The report shows the summary of all counts.
TPL_004	Member Match Summary	This report shows a count of the number of members enrolled as of a given date. Results are based on benefit plan assignment.
TPL_005	TPL Coverage Control	This report shows the record details generated as a result of running the batch TPL update process.
TPL_006	TPL Coverage Loading Error	This report shows the record details generated because of coverage load.
TPL_007	TPL Member Level Error	This report shows the record details generated as a result of running the batch TPL update process.
TPL_007	Partial Coverage Aging	This report provides TPL Coverage Partial Match Record IDs for which the coverage termination effective date falls within 30 and 33 months prior to the current report run date.

Report ID	Report Name	Report Description
TPL_008	Partial Payer Summary	This report provides summary statistics for the count of TPL Coverage Partial Match Records for each Payer and Match Grade. Additionally, the second tab of the report lists the unique comments provided when TPL Coverage Partial Match Records are marked "Excluded From Review" and the count of excluded records per comment.
TPL_009	Partial Purge	This report provides summary and detail statistics for TPL Coverage Partial Match Records purged/not loaded according to business rules found in TPL Coverage Partial Match Record Pre-Screening.
TPL_010	Age of Pending TPL Leads	This report provides summary statistics for the count of pending TPL Leads across defined time ranges per assigned user.
TPL_011	Partial Pending	This report provides summary statistics for the count of pending TPL Coverage Partial Match Records across defined time ranges for selected users and payers.
TPL_012	Partial User Productivity	This report provides detailed and summary statistics related to user and/or organizational unit productivity processing TPL Coverage Partial Match Records.
TPL_013	TPL Missing MBI	This report provides a list of Medicaid IDs and associated Health Insurance Claim Number (HICN) for members without a current Medicare Beneficiary ID (MBI).
TPL_014	Open SRs with TPL	This report is required for TPL to find SRs that are in open status for more than five days.
CM_001	Managed Care Rates by Plan	This Cognos report lists the Managed Care Rate Cells by plan.
CM_002	Managed Care Rates by Plan with Detail	This Cognos report lists the Managed Care Rate Cells by plan.
CM_003	Managed Care Rates by Region	This Cognos report lists the Managed Care Rate Cells by region.
CM_004	Managed Care Rates by Region with Detail	This Cognos report lists the Managed Care Rate Cells by region.
CM_005	Managed Care Capitation Payment Report – County	This Cognos report lists capitation payments by County.
CM_006	Managed Care Capitation Payment - Provider	This Cognos report lists capitation payments by provider.
CM_007	Managed Care 834/820 Reconciliation Monthly - External	This report displays the latest active eligibility transaction and benefit plan status of 834 transactions not receiving an associated 820 payment transactions, including the spend down Benefit 834 transactions.
CM_008	Managed Care 834/820 Reconciliation Monthly - Internal	This report displays the latest active eligibility transaction and benefit plan status of 834 transactions not receiving an associated 820 payment transaction.
CM_009	Network Panel by Managed Care Organization	This report lists provider details grouped by associated MCO.
CM_010	PCP Assignment	Displays PCP and health plan assignments for beneficiaries.
CM_011	Performance Bonus	This report provides information to assist managed care policy staff in making their annual performance bonus award to MCOs.
CM_012	Plan Capacity and Enrollment	Displays the total capacity and enrollment for each plan by County.

Report ID	Report Name	Report Description
CM_013	Managed Care Rates By Region with Medicare Factor	This Cognos report lists the Managed Care Rate Cells by Program Eligibility Group.
CM_014	Managed Care Rates By Region with Medicare Factor and Detail	This Cognos report lists the Managed Care Rate Cells by Program Eligibility Group.
CM_015	Managed Care Capitation Payment Withhold Report – Program	This report details the payment withhold amounts for a certain program by provider.

Figure 3.10.13-3. Standardized Operational Reports. Team CNSI's offers a library of over 170 standardized operational reports.

CDR01

The Contractor's solution shall track, maintain, store, and report data from all claims transaction types (e.g., fee for service, encounter) as defined by the Agency.

The evoBrix X Core Claims module tracks, maintains, stores, and reports data from all claim transaction types (e.g., fee for service, encounter) as defined by DPHHS. Our solution includes a set of pre-defined reports and extensible reporting functionality comprised of a standard structured set of data elements that cover all claim transaction types. Team CNSI can configure the Core Claims module to produce scheduled or on-demand reports and create an enhanced self-service user experience through ad-hoc reports according to DPHHS requirements.

Figure 3.10.13-4 shows an ad hoc report used to track all claim transactional types where "Claim Type" describes the type of the claim transaction.

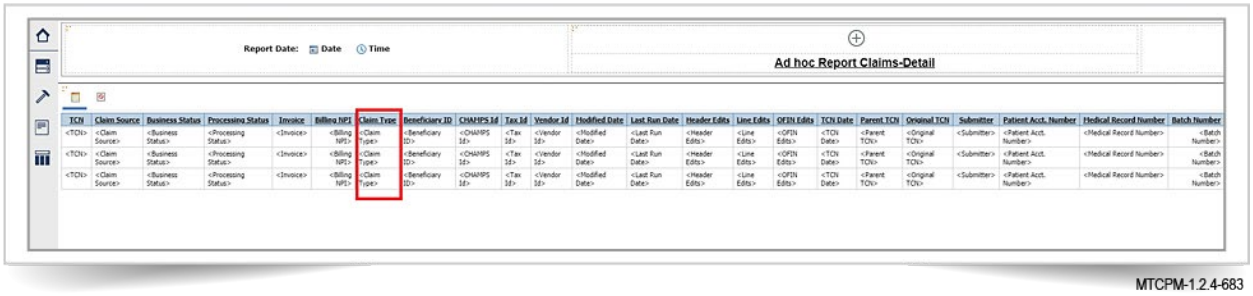


Figure 3.10.13-4. Claims detail ad hoc report. An ad hoc report developed to track all claim transactional types where "Claim Type" describes the type of the claim transaction.

CDR02

The contractor's solution shall have the capability to capture, track, store, maintain and report the status of all claims related grievances and appeals from receipt to determination, as defined by the Agency (e.g., number of grievances/appeals received, resolved, rejected, escalated, and timeframe of resolution) as defined by the Agency.

The evoBrix X Core Claims module captures, tracks, stores, maintains, and reports the status of all claims-related grievances and appeals (e.g., number of grievances/appeals received, resolved, rejected, escalated, and timeframe of resolution) from receipt to determination, as defined by DPHHS. Our solution allows us to develop a business process to receive all appeals and grievances specific data for the processed claims from Agency. Our solution leverages configurable and dynamic templates to define a set of steps and activities to receive store and maintain the data. We can configure standard, conditional, and dynamic activities (mandatory or non-mandatory, automatic or manual, and recurring or non-recurring)

based on the business process defined by the Agency. The process allows for the initiation of dynamic, ad-hoc activity that cannot be predicted in advance within the grievance and appeals process.

Our solution electronically tracks and reports grievances and appeals at each stage to ensure compliance with DPHHS-defined process. An applicable report includes information regarding electronic access to appeal documentation and associated information, research, recommendations, and attachments to claims, at a minimum.

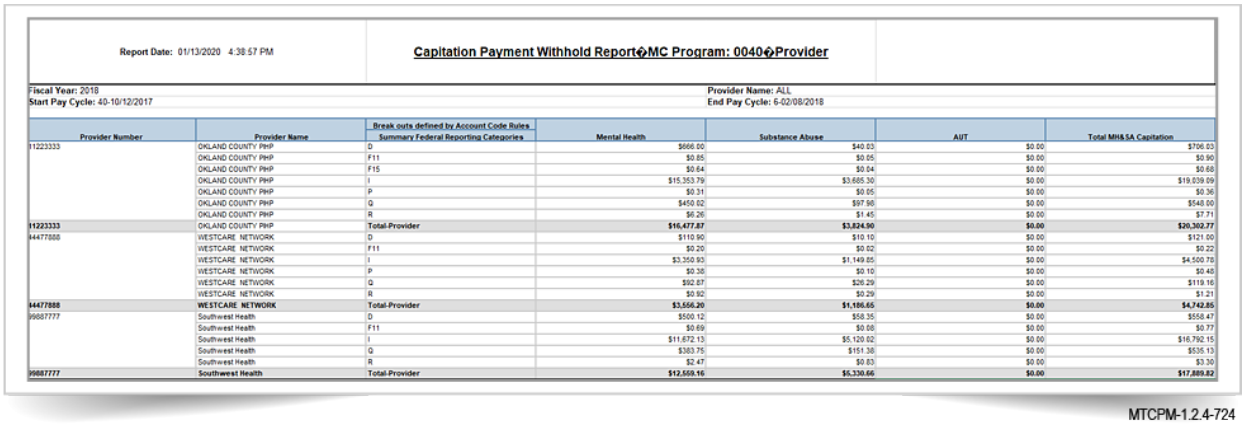
CDR03

The Contractor's solution shall create, maintain, and store payment reports as defined by the Agency (i.e., Per member per month, NET or other capitation payments)

The evoBrix X Core Claims module uses MCO assignments and eligibility details received from the external system to automatically generate monthly capitations. Our capitation solution allows the following:

- Preparation of PMPM capitation calculation
- Preparation of service-based enhancement fees to MCOs
- Preparation of member-level rate adjustments
- Funds (account strings) determination and validation
- Interfaces with the external trading partners

The evoBrix X Core Claims module creates, maintains, and stores payment reports per DPHHS requirements. Our solution includes a pre-defined set of reports (e.g., Managed Care Capitation Payment, Managed Care 834/820 Reconciliation, Managed Care Capitation Payment Withhold, etc.) that provides information on all capitation payment transactions in detail and summary form. In addition, users can access our extensible reporting model to create an enhanced self-service user experience through ad-hoc reports according to DPHHS requirements. We have included a sample report as Figure 3.10.13-5.



Report Date: 01/13/2020 4:38:57 PM

Capitation Payment Withhold Report–MC Program: 0040–Provider

Fiscal Year: 2018
Start Pay Cycle: 40-10/12/2017
Provider Name: ALL
End Pay Cycle: 6-02/08/2018

Provider Number	Provider Name	Break outs defined by Account Code Rules Summary Federal Reporting Categories	Mental Health	Substance Abuse	AUT	Total MH&SA Capitation
11223333	OKLAND COUNTY PHP	D	$666.00	$40.03	$0.00	$706.03
	OKLAND COUNTY PHP	F11	$0.85	$0.05	$0.00	$0.90
	OKLAND COUNTY PHP	F15	$0.64	$0.04	$0.00	$0.68
	OKLAND COUNTY PHP	I	$15,353.79	$3,685.30	$0.00	$19,039.09
	OKLAND COUNTY PHP	P	$0.31	$0.05	$0.00	$0.36
	OKLAND COUNTY PHP	Q	$450.02	$97.98	$0.00	$548.00
	OKLAND COUNTY PHP	R	$6.26	$1.45	$0.00	$7.71
11223333	OKLAND COUNTY PHP	**Total-Provider**	**$16,477.87**	**$3,824.90**	**$0.00**	**$20,302.77**
44477888	WESTCARE NETWORK	D	$110.90	$10.10	$0.00	$121.00
	WESTCARE NETWORK	F11	$0.20	$0.02	$0.00	$0.22
	WESTCARE NETWORK	I	$3,350.93	$1,149.85	$0.00	$4,500.78
	WESTCARE NETWORK	P	$0.38	$0.10	$0.00	$0.48
	WESTCARE NETWORK	Q	$92.87	$26.29	$0.00	$119.16
	WESTCARE NETWORK	R	$0.92	$0.29	$0.00	$1.21
44477888	**WESTCARE NETWORK**	**Total-Provider**	**$3,556.20**	**$1,186.65**	**$0.00**	**$4,742.85**
99687777	Southwest Health	D	$500.12	$58.35	$0.00	$558.47
	Southwest Health	F11	$0.69	$0.08	$0.00	$0.77
	Southwest Health	I	$11,672.13	$5,120.02	$0.00	$16,792.15
	Southwest Health	Q	$383.75	$151.38	$0.00	$535.13
	Southwest Health	R	$2.47	$0.83	$0.00	$3.30
99687777	Southwest Health	**Total-Provider**	**$12,559.16**	**$5,330.66**	**$0.00**	**$17,889.82**

MTCPM-1.2.4-724

Figure 3.10.13-5. Capitation Payment Withhold Report by Program. A pre-defined report that details the payment withhold amounts for a certain program by provider.

CDR04

The Contractor's solution shall identify, track, audit and report managed care transactions (e.g., service data, payments) for all healthcare programs, as defined by the Agency.

The evoBrix X Core Claims module data model includes data structures designed to process, store, and maintain capitation payment information. The reporting capability comes with a set of pre-defined reports used to identify, track, audit, and report information on managed care transactions for all healthcare programs per DPHHS requirements. Users can leverage our extensible reporting model relying on the capitation payment data mart to create an enhanced self-service user experience through ad-hoc payment reports according to DPHHS requirements. We list the pre-defined Managed Care reports in Figure 3.10.13-6:

Report ID	Report Name	Report Description
CM_001	Managed Care Rates By Plan	This Cognos report lists the Managed Care Rate Cells by plan.
CM_002	Managed Care Rates By Plan with Detail	This Cognos report lists the Managed Care Rate Cells by plan.
CM_003	Managed Care Rates By Region	This Cognos report lists the Managed Care Rate Cells by region.
CM_004	Managed Care Rates By Region with Detail	This Cognos report lists the Managed Care Rate Cells by region.
CM_005	Managed Care Capitation Payment Report – County	This Cognos report lists capitation payments by County.
CM_006	Managed Care Capitation Payment - Provider	This Cognos report lists capitation payments by provider.
CM_007	Managed Care 834/820 Reconciliation Monthly – External	This report displays the latest active eligibility transaction and benefit plan status of 834 transactions not receiving an associated 820 payment transactions, including the spend down Benefit 834 transactions.
CM_008	Managed Care 834/820 Reconciliation Monthly – Internal	This report displays the latest active eligibility transaction and benefit plan status of 834 transactions not receiving an associated 820 payment transaction.
CM_009	Network Panel by MCO	This report lists provider details grouped by associated MCO.
CM_010	PCP Assignment	Displays PCP and health plan assignments for beneficiaries.
CM_011	Performance Bonus	This report provides information to assist managed care policy staff in making their annual performance bonus award to MCOs.
CM_012	Plan Capacity and Enrollment	Displays the total capacity and enrollment for each plan by County.
CM_013	Managed Care Rates By Region with Medicare Factor	This Cognos report lists the Managed Care Rate Cells by Program Eligibility Group.
CM_014	Managed Care Rates By Region with Medicare Factor and Detail	This Cognos report lists the Managed Care Rate Cells by Program Eligibility Group.

Report ID	Report Name	Report Description
CM_015	Managed Care Capitation Payment Withhold Report – Program	This report details the payment withhold amounts for a certain program by provider.

Figure 3.10.13-6. List of Pre-defined Managed Care Reports. Team CNSI's evoBrix X Core Claims includes data structures designed to process, store, and maintain capitation payment information.

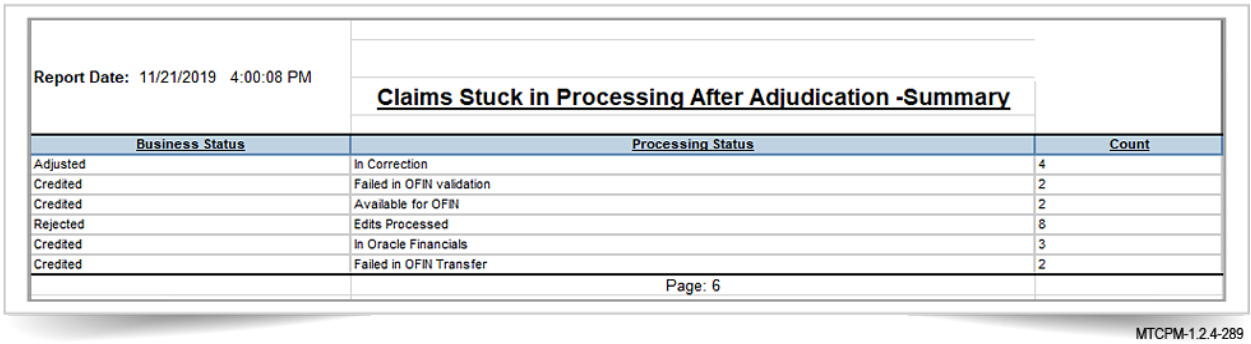
CDR05

The Contractor's solution shall store, maintain, track, display and report all claims processing activity throughout the adjudication process (e.g., backlog, suspended claims by status and location, manual entry, adjustments) as defined by the Agency.

The evoBrix X Core Claims module stores, maintains, tracks, displays, and reports all claims processing activity throughout the adjudication process (e.g., backlog, suspended claims by status and location, manual entry, adjustments) as defined by DPHHS. Our solution tracks all incoming claim transaction types (e.g., fee for service and encounters) from their intake to adjudication and then to payment as a critical part of our operational processes.

The evoBrix X Core Claims module includes a set of pre-defined activity tracking reports (e.g., Claims Stuck in Processing, Aging Claims Suspended, Adjudication Throughput Analysis, and Dashboards) to pro-actively monitor claims status. Timely alerts trigger prompt actions by operations staff, which enables them to avoid potential backlogs throughout the claim life cycle. Our solution provides a holistic view of claims operations to ensure accurate reporting and alignment with SLAs.

Team CNSI has included a sample Claims Stuck in Processing Report as Figure 3.10.13-7.



Report Date: 11/21/2019 4:00:08 PM

Claims Stuck in Processing After Adjudication -Summary

Business Status	Processing Status	Count
Adjusted	In Correction	4
Credited	Failed in OFIN validation	2
Credited	Available for OFIN	2
Rejected	Edits Processed	8
Credited	In Oracle Financials	3
Credited	Failed in OFIN Transfer	2

Page: 6

MTCPM-1.2.4-289

Figure 3.10.13-7. Claims Stuck in Processing Report. Pre-defined report that shows the details of claims stuck in processing at various stages of their life cycle.

CDR07

The Contractor's solution shall identify, track and report claims flagged for investigation due to suspect or confirmed third-party liability discrepancies as defined by the Agency.

The evoBrix X Core Claims module identifies, tracks, and reports claims flagged for investigation due to suspect or confirmed TPL discrepancies as defined by DPHHS. Our solution includes a set of pre-defined reports (e.g., Error Code Count - Daily, Suspended Claims) that provide information on claims along with the corresponding TPL edit information, if any, to identify discrepancies. In addition, authorized users can leverage an extensible reporting model that includes a standard structured set of data elements for an enhanced self-service user experience using DPHHS-defined ad-hoc reports.

Figure 3.10.13-8 shows the layout of the Suspended Claims Report where the field "Edit" displays the related TPL edit information that can be used to identify relevant claims.

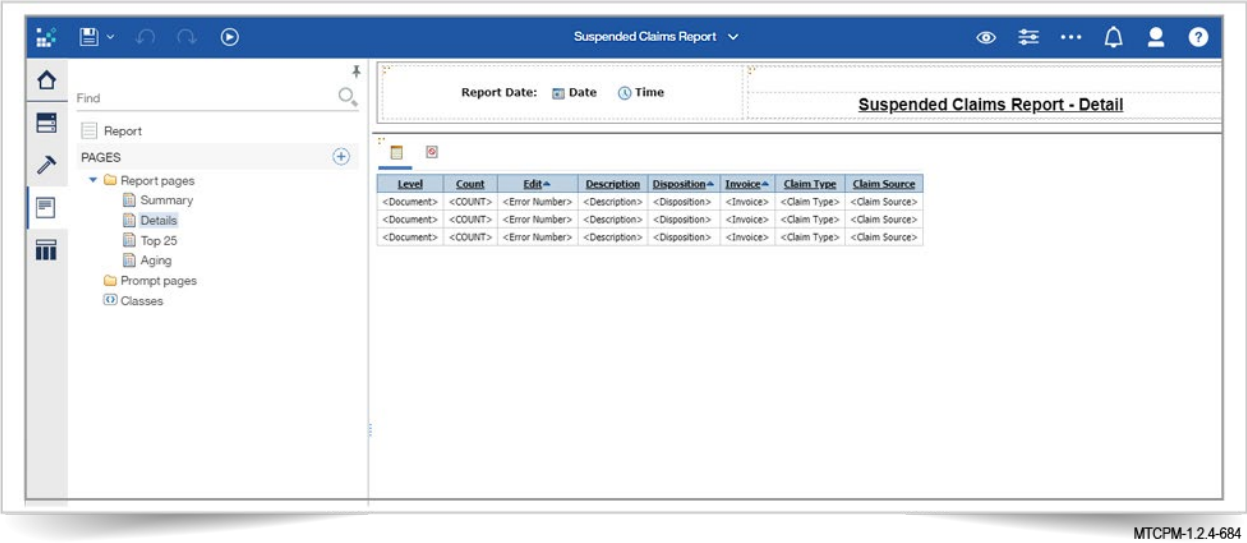


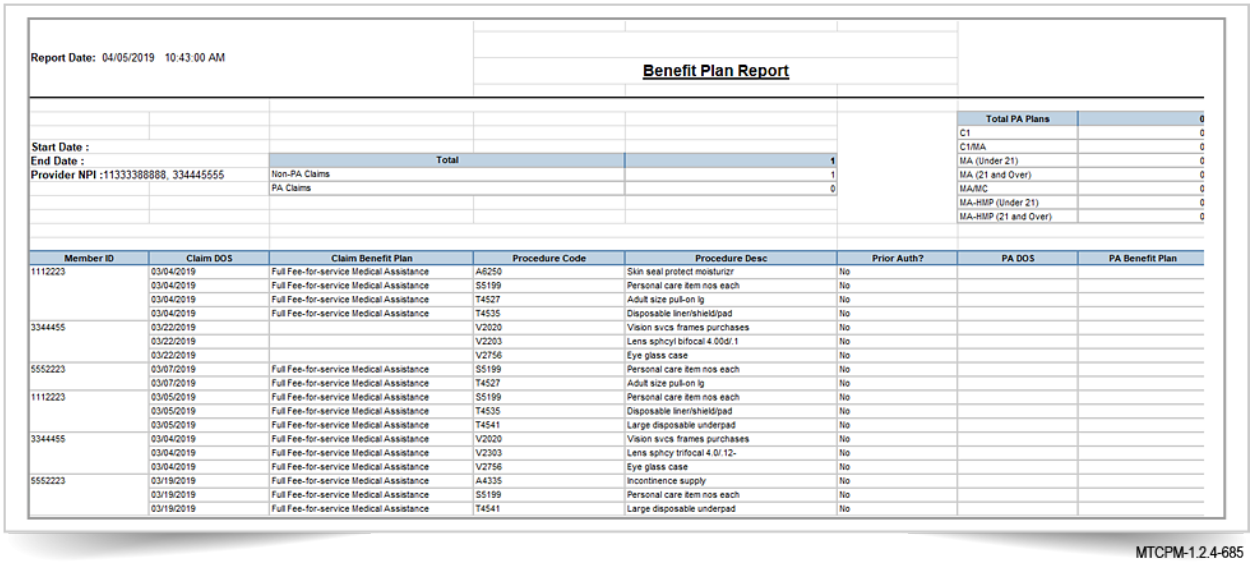
Figure 3.10.13-8. Suspended Claims Report. Pre-defined report layout where the field "Edit" shows the related TPL edit information that can be used to identify relevant claims.

CDR08

The Contractor's solution shall maintain and report on all service authorization activity (e.g., requests, determinations, responses and utilization), as defined by the Agency.

The evoBrix X Core Claims module maintains and reports on all service authorization activity (e.g., requests, determinations, responses and utilization), as defined by DPHHS. Our solution's data model includes a service authorization data mart that tracks all PA requests and maintains a relationship with the corresponding claims. Our solution's reporting capabilities feature summary and detail reports (e.g., Benefit Plan, Batch Verification, Internal Monitoring) that include information on these PA requests and their corresponding claims and utilization. In addition, as stated, authorized users can leverage an extensible reporting model that includes a standard structured set of data elements for an enhanced self-service user experience using DPHHS-defined ad-hoc reports.

Figure 3.10.13-9 shows a sample output of a Prior Authorization Benefit Plan Report that displays the tracking of PA requests to corresponding claims.



Report Date: 04/05/2019 10:43:00 AM

Benefit Plan Report

Start Date :
End Date :
Provider NPI :11333388888, 334445555

Total	1
Non-PA Claims	1
PA Claims	0

Total PA Plans	0
C1	0
C1/MA	0
MA (Under 21)	0
MA (21 and Over)	0
MA/MC	0
MA-HMP (Under 21)	0
MA-HMP (21 and Over)	0

Member ID	Claim DOS	Claim Benefit Plan	Procedure Code	Procedure Desc	Prior Auth?	PA DOS	PA Benefit Plan
1112223	03/04/2019	Full Fee-for-service Medical Assistance	A6250	Skin seal protect moisturizr	No		
	03/04/2019	Full Fee-for-service Medical Assistance	S5199	Personal care item nos each	No		
	03/04/2019	Full Fee-for-service Medical Assistance	T4527	Adult size pull-on lg	No		
	03/04/2019	Full Fee-for-service Medical Assistance	T4535	Disposable liner/shield/pad	No		
3344455	03/22/2019		V2020	Vision svcs frames purchases	No		
	03/22/2019		V2203	Lens sphcyl bifocal 4.00d/.1	No		
	03/22/2019		V2756	Eye glass case	No		
5552223	03/07/2019	Full Fee-for-service Medical Assistance	S5199	Personal care item nos each	No		
	03/07/2019	Full Fee-for-service Medical Assistance	T4527	Adult size pull-on lg	No		
1112223	03/05/2019	Full Fee-for-service Medical Assistance	S5199	Personal care item nos each	No		
	03/05/2019	Full Fee-for-service Medical Assistance	T4535	Disposable liner/shield/pad	No		
	03/05/2019	Full Fee-for-service Medical Assistance	T4541	Large disposable underpad	No		
3344455	03/04/2019	Full Fee-for-service Medical Assistance	V2020	Vision svcs frames purchases	No		
	03/04/2019	Full Fee-for-service Medical Assistance	V2303	Lens sphcy trifocal 4.0/.12-	No		
	03/04/2019	Full Fee-for-service Medical Assistance	V2756	Eye glass case	No		
5552223	03/19/2019	Full Fee-for-service Medical Assistance	A4335	Incontinence supply	No		
	03/19/2019	Full Fee-for-service Medical Assistance	S5199	Personal care item nos each	No		
	03/19/2019	Full Fee-for-service Medical Assistance	T4541	Large disposable underpad	No		

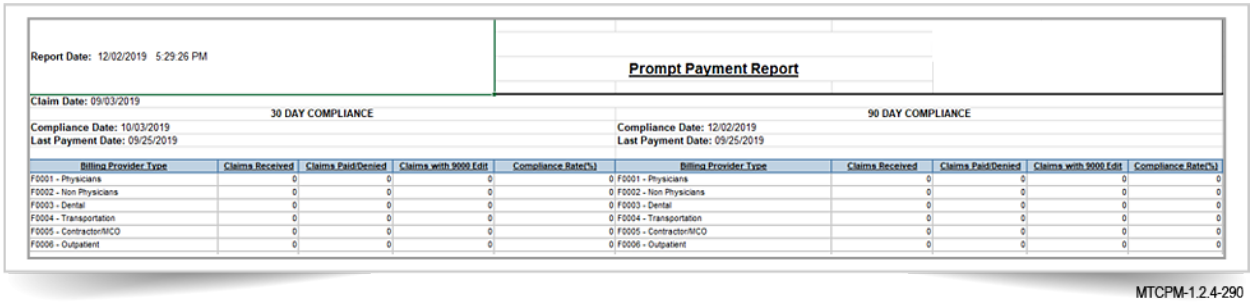
MTCPM-1.2.4-685

Figure 3.10.13-9. Benefit Plan Report. Pre-defined PA Benefit Plan Report identifies any claims returned that were prior authorized and displays the Prior Authorized Date of Service and Prior Authorized Benefit Plan.

CDR09

The Contractor's solution shall maintain, track, and report claims data (e.g., prompt payment of clean claims, claims inventory) to support compliance with 42 CFR 447.45

The evoBrix X Core Claims module maintains, tracks, and reports claims data (e.g., prompt payment of clean claims, claims inventory) to support compliance with 42 CFR 447.45. Our solution's reporting functionality includes a set of pre-defined reports (e.g., Prompt Payment, Prompt Payment History, Average Days from Date of Service to Date of Payment Trend) that include summary and/or detailed information on timely payment of claims to support compliance with 42 CFR 447.45. Team CNSI has included a sample Prompt Payment Report as Figure 3.10.13-10.



Report Date: 12/02/2019 5:29:26 PM

Prompt Payment Report

Claim Date: 09/03/2019

30 DAY COMPLIANCE
Compliance Date: 10/03/2019
Last Payment Date: 09/25/2019

Billing Provider Type	Claims Received	Claims Paid/Denied	Claims with 9000 Edit	Compliance Rate(%)
F0001 - Physicians	0	0	0	0
F0002 - Non Physicians	0	0	0	0
F0003 - Dental	0	0	0	0
F0004 - Transportation	0	0	0	0
F0005 - Contractor/MCO	0	0	0	0
F0006 - Outpatient	0	0	0	0

90 DAY COMPLIANCE
Compliance Date: 12/02/2019
Last Payment Date: 09/25/2019

Billing Provider Type	Claims Received	Claims Paid/Denied	Claims with 9000 Edit	Compliance Rate(%)
F0001 - Physicians	0	0	0	0
F0002 - Non Physicians	0	0	0	0
F0003 - Dental	0	0	0	0
F0004 - Transportation	0	0	0	0
F0005 - Contractor/MCO	0	0	0	0
F0006 - Outpatient	0	0	0	0

MTCPM-1.2.4-290

Figure 3.10.13-10. Prompt Payment Report. Pre-defined report that shows statistics of claims' 30-day and 90-day compliance.

CDR10

The Contractor's solution shall maintain, track, provide audit history, and report all financial transactions between Entities and the Agency (e.g., payments, takebacks, receivables, credit balance, claims), as defined by the Agency

The evoBrix X Core Claims module maintains, tracks, provides audit history, and reports all financial transactions between entities and DPHHS (e.g., payments, takebacks, receivables, credit balance, claims), as defined by DPHHS. The Remittance Advice generated via our claims adjudication and payment

process contains information regarding the provider, claims, adjustment reason codes, payments, offsets, takebacks, receivables, and credit balances. In addition, as stated, authorized users can leverage an extensible reporting model that includes a standard structured set of data elements for an enhanced self-service user experience using DPHHS-defined ad-hoc reports.

CDR11

The Contractor's solution shall track, maintain, and report recoveries for the federal share of overpayments to support compliance with 42 CFR 433.320 as defined by the Agency.

The Option A- Financial Services module of evoBrix X tracks, maintains, and reports recoveries for the federal share of overpayments to support compliance with 42 CFR 433.320 as defined by DPHHS. The solution includes a set of pre-defined Financial reports (e.g., Medicaid Overpayment Adjustment and Recoveries FIN Only) that provides information on recoveries and overpayments in compliance with 42 CFR 433.320. Team CNSI has included a sample Recoveries FIN Report as Figure 3.10.13-11.

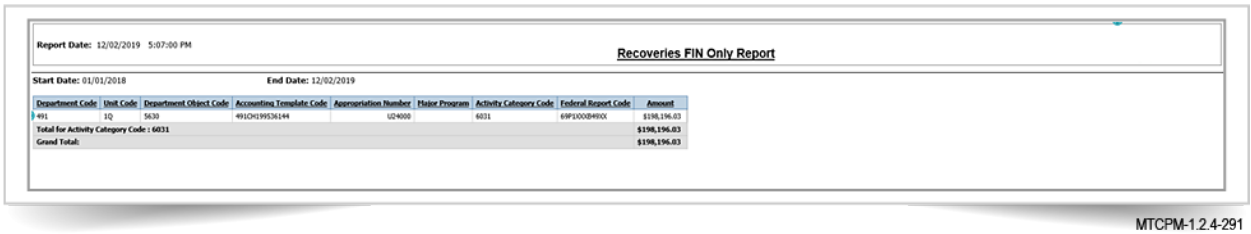


Figure 3.10.13-11. Recoveries FIN Report. Pre-defined report that provides information on FIN recovery transactions.

CDR12

The Contractor's solution shall track, store, and maintain, and report all user activity (e.g., access history, claims editing, provider updates, benefit plan changes, rate and fee schedule changes) as defined by the Agency.

The evoBrix X Core Claims module tracks, stores, maintains, and reports all user activity (e.g., access history, claims editing, provider updates, benefit plan changes, rate and fee schedule changes) as defined by DPHHS. Each data structure of the Core Claims module's data model maintains audit information upon creation as well as any subsequent modification to a specific transaction. This information can be monitored through the Prior Authorization Logged On Report, as shown in Figure 3.10.13-12.

Our solution's extensible reporting model that facilitates ad hoc reporting can leverage data in the underlying data model to provide authorized users with information related to access history and reference data changes.

Report Date: 10/28/2019 8:30:01 PM

Logged On Report

Log on Date : 10/28/2019

Entered By	Specialty	Request Date	Beneficiary ID	Beneficiary Name	Tracking Number	Logged On Date	Assigned To	Source
Barry, Allen	1	10/28/2019			1000773845	10/28/2019	Barry, Allen	FX
					1000773684	10/28/2019	Barry, Allen	FX
	1				2			
Barry, Allen					2			
Jean, Annette	12	10/25/2019			1000773809	10/28/2019	Driver, Adam	FX
	12				1			
	35	10/25/2019			1000773721	10/28/2019	Jean, Annette	MP
					1000773770	10/28/2019	Jean, Annette	MP
					1000773686	10/28/2019	Jean, Annette	MP
					1000773751	10/28/2019	Jean, Annette	MP
					1000773720	10/28/2019	Jean, Annette	MP
					1000773730	10/28/2019	Jean, Annette	MP
					1000773677	10/28/2019	Jean, Annette	MP
					1000773734	10/28/2019	Jean, Annette	MP
					1000773683	10/28/2019	Jean, Annette	MP
					1000773787	10/28/2019	Jean, Annette	MP
					1000773775	10/28/2019	Jean, Annette	MP
					1000773706	10/28/2019	Jean, Annette	MP
					1000773738	10/28/2019	Jean, Annette	MP
					1000773745	10/28/2019	Jean, Annette	MP
					1000773679	10/28/2019	Jean, Annette	MP
					1000773680	10/28/2019	Jean, Annette	MP
					1000773778	10/28/2019	Jean, Annette	MP
					1000773704	10/28/2019	Jean, Annette	MP
					1000773727	10/28/2019	Jean, Annette	MP
					1000773781	10/28/2019	Jean, Annette	MP
					1000773717	10/28/2019	Jean, Annette	MP
					1000773689	10/28/2019	Jean, Annette	MP
					1000773735	10/28/2019	Jean, Annette	MP
					1000773772	10/28/2019	Jean, Annette	MP
					1000773791	10/28/2019	Jean, Annette	MP
					1000773790	10/28/2019	Jean, Annette	MP
					1000773746	10/28/2019	Jean, Annette	MP
					1000773785	10/28/2019	Frosty, Annette	MP

MTCPM-1.2.4-686

Figure 3.10.13-12. Prior Authorization Logged on Report. Pre-defined report that provides information on PAs logged on by user.

CDR13

The Contractor's solution shall identify, track, store, and report detailed information supporting history-only recoveries and payments as defined by the Agency.

The Option A – Financial Module of evoBrix X Core Claims module identifies, tracks, stores, and reports detailed information supporting history-only recoveries and payments as defined by DPHHS. Our solution's data model includes structures needed to maintain recovery and payment information in the Financial data mart. The reporting capability provides pre-defined reports for recoveries and payments (e.g., Payment Summary, Payment Action and Reconciliation, Recoveries Only) that provide details on all recoveries and payment transactions stored and maintained in the Financial data model and its structures.

In addition, as stated, authorized users can leverage an extensible reporting model that includes a standard structured set of data elements for an enhanced self-service user experience using DPHHS-defined ad-hoc reports.

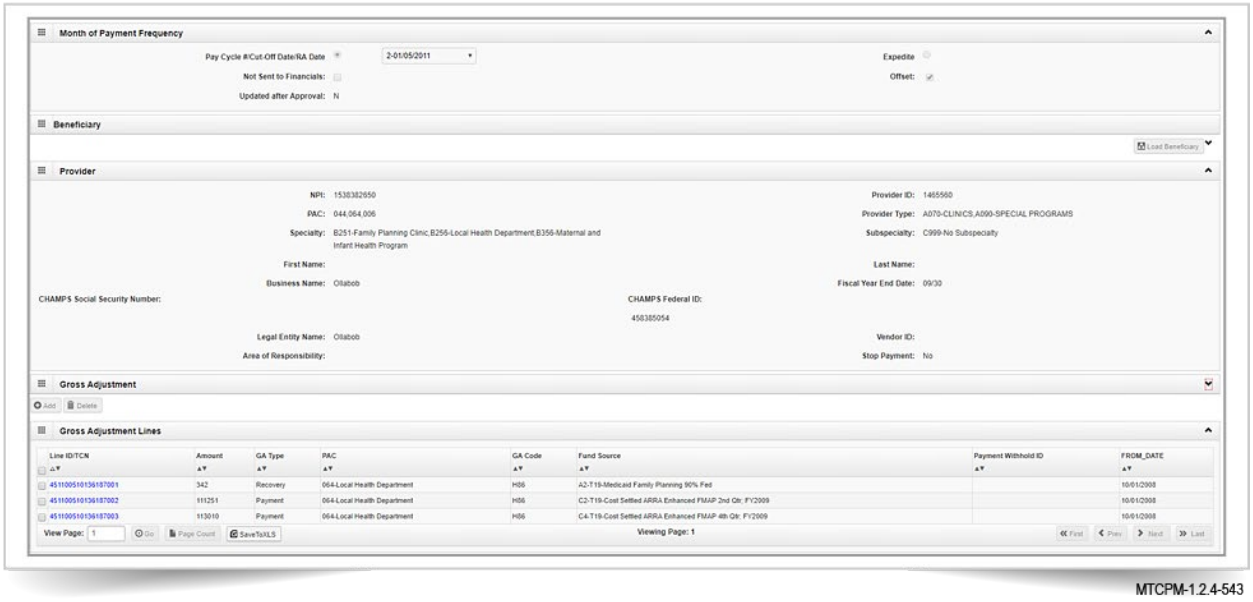
CDR14

The Contractor's solution shall identify, track, audit, and report inter and intra-governmental payments and receivables (e.g., Qualified Rate Adjustments (QRA's) and Upper Payment Limits (UPLs)) as defined by the Agency.

The evoBrix X Core Claims module identifies, tracks, audits, and reports inter and intra-governmental payments and receivables (e.g., Qualified Rate Adjustments [QRAs] and Upper Payment Limits [UPLs]) as defined by DPHHS. Users can create non-claim related transactions using our solution's gross adjustment functionality.

A gross adjustment created in our solution can include various attributes such as Adjustment Reason, Receivable Type, and Funding Title. Team CNSI can appropriately configure these attributes to uniquely identify transactions for various reasons (e.g., QRA and UPL payments). The Core Claims module assigns a TCN number, account coding, status, amount, etc. to gross adjustments.

Figure 3.10.13-13 illustrates where authorized users can access gross adjustment information.



MTCPM-1.2.4-543

Figure 3.10.13-13. Gross Adjustment Screen. Application screen that provides information on a specific gross adjustment.

CDR15

The Contractor's solution shall have the ability for authorized users to run pre-defined and ad hoc queries on claims data within the solution for reporting, as defined by the Agency.

The evoBrix X Core Claims module allows authorized users to run pre-defined and ad hoc queries on claims data for reporting, as defined by DPHHS. Our solution includes an extensible reporting model comprised of a standard structured set of data elements as a part of Claims and Financial Reporting, which brings transparency to ensure proper operation of the system.

Our solution can be configured to provide an enhanced self-service user experience through ad-hoc reports according to DPHHS requirements. Authorized users can access aggregated data with different dimensions or the underlying detailed data to support critical day-to-day business activities.

Figure 3.10.13-14 illustrates a model ad hoc subject area, which we can modify to meet DPHHS-specific needs. Figure 3.10.13-15 shows an example of an on-demand report.

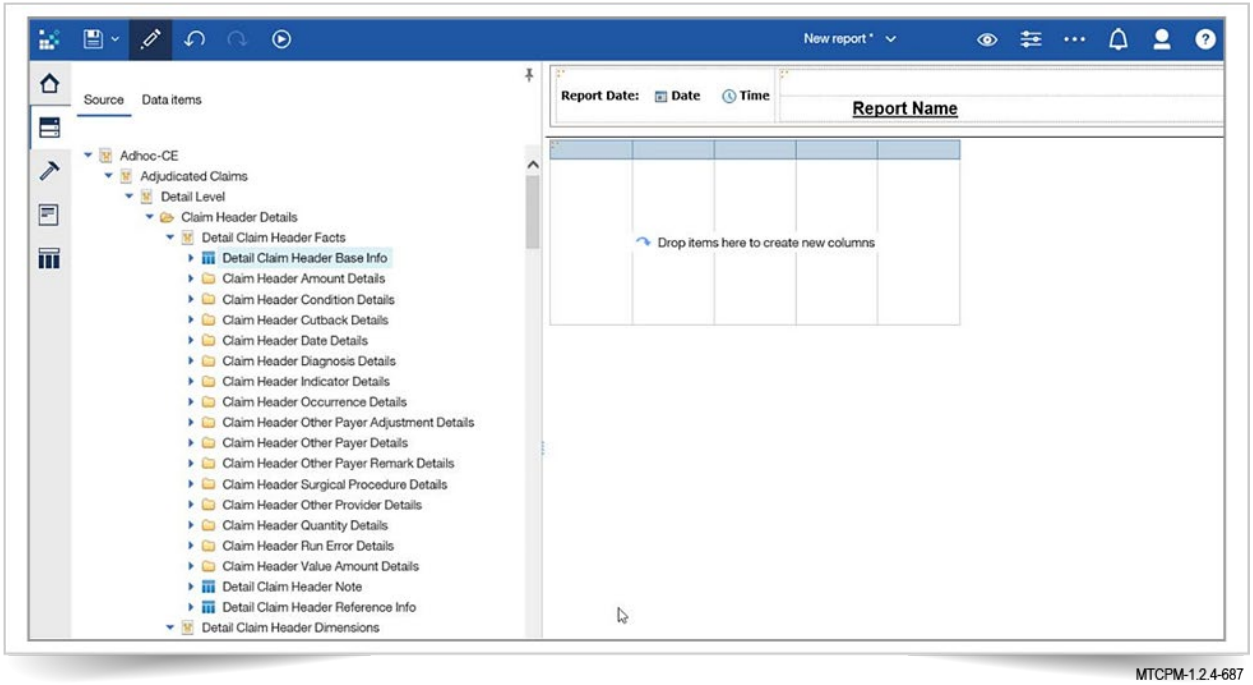


Figure 3.10.13-14. Model claims ad hoc subject area. Ad hoc model report template where Team CNSI can design new reports. Users can drag and drop the elements from the Ad hoc-CE package on to the design layout to create their own customized reports.

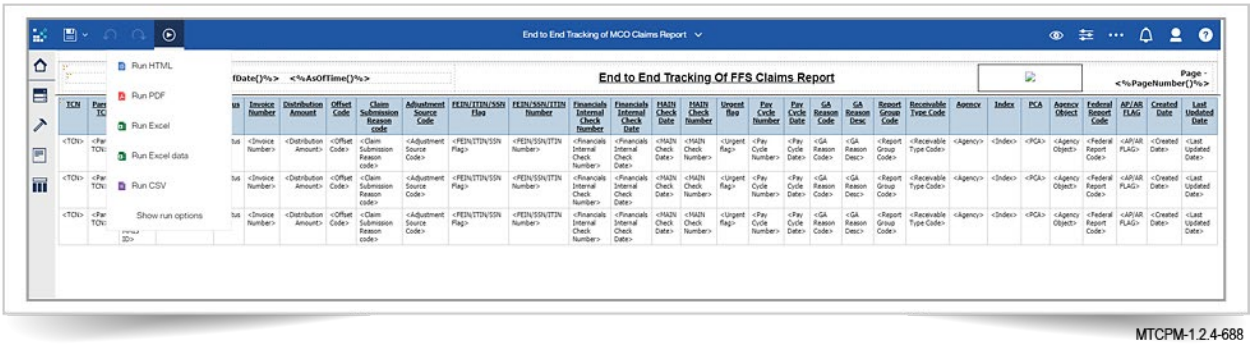


Figure 3.10.13-15. End to End Tracking Of FFS Claims Report. Users can execute reports on demand, and the output downloaded in various formats as shown.

CDR16

The Contractor shall analyze and report on proposed reference file changes (e.g. Benefit Plan, provider rate changes, taxonomy updates, category of service updates) as defined by the Agency.

The evoBrix X Core Claims module includes functionality to allow authorized users to analyze and report on proposed reference file changes (e.g. Benefit Plan, provider rate changes, taxonomy updates, category of service updates) as defined by DPHHS. Our solution includes an extensible reporting model comprised of a standard structured set of data elements as a part of Claims and Financial Reporting, which brings transparency to ensure proper operation of the system.

Our solution provides an enhanced self-service user experience through ad-hoc reports and creates impact analysis reports on proposed changes to reference data. Leveraging our solution and DPHHS-provided benefit plan updates, Team CNSI's Business Operations members can efficiently run what-if models to assess the impact of benefit plan changes. Analysis results include the volume of claims and PAs impacted by a change as well as a projection of the financial impact to DPHHS and providers. Additionally, our solution enables authorized users to perform data exploration and analysis through varying dimensions. We share results of any analysis with DPHHS.

CDR17

The Contractor's solution shall produce premium collection reports, per Agency defined criteria.

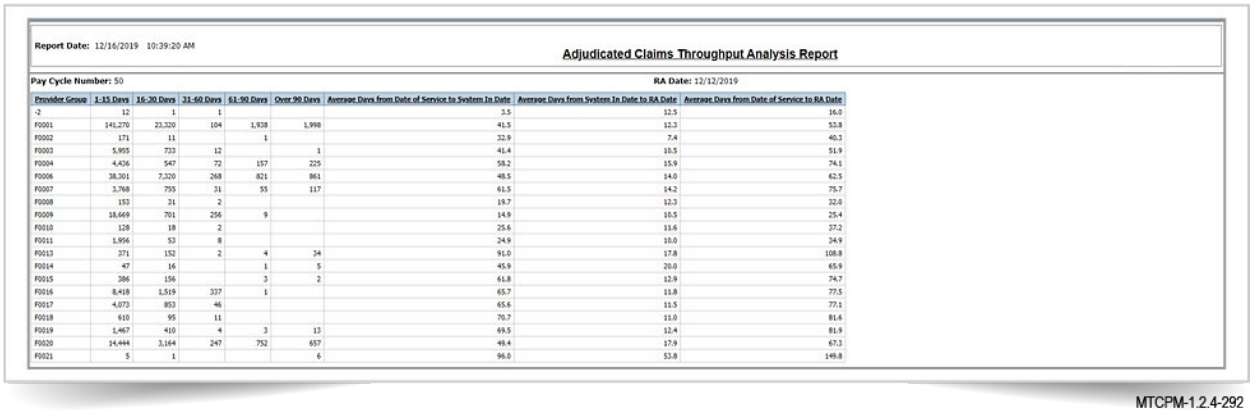
The Option A – Financial Module of evoBrix X Core Claims module produces premium collection reports, per DPHHS-defined criteria. Our solution's data model receives premium collection information from DPHHS' payment source through the System Integrator. We store the information in data structures that facilitate ad hoc reporting through the extensible reporting model. Ad hoc reporting helps users create and generate premium collection reports.

CDR18

The Contractor's solution shall monitor, track, and report on claims processing quality standards (e.g. percentage of claims resolved, keying error rate, etc.) as defined by the Agency

The evoBrix X Core Claims module monitors, tracks, and reports on claims processing quality standards (e.g. percentage of claims resolved, keying error rate, etc.) as defined by DPHHS. Our solution includes a set of pre-defined reports (e.g., Suspended Claims, Adjudicated Claims Throughput Analysis, Total Claims Processed Trend, and Operational Performance Summary) that detail metrics and summarized information on claims resolution and processing quality.

Team CNSI has included a sample Adjudicated Claims Throughput Analysis Report as Figure 3.10.13-16.


Report Date: 12/16/2019 10:39:20 AM

Adjudicated Claims Throughput Analysis Report

Pay Cycle Number: 50 RA Date: 12/12/2019

Provider Group	1-15 Days	16-30 Days	31-60 Days	61-90 Days	Over 90 Days	Average Days from Date of Service to System In Date	Average Days from System In Date to RA Date	Average Days from Date of Service to RA Date
-2	12	1	1			3.5	12.5	16.0
F0001	141,270	23,320	104	1,938	1,998	41.5	12.3	53.8
F0002	171	11		1		32.9	7.4	40.3
F0003	5,955	733	12		1	41.4	10.5	51.9
F0004	4,456	547	72	157	225	58.2	15.9	74.1
F0006	38,301	7,320	268	821	861	48.5	14.0	62.5
F0007	3,768	755	31	55	117	61.5	14.2	75.7
F0008	153	31	2			19.7	12.3	32.0
F0009	18,669	701	256	9		14.9	10.5	25.4
F0010	128	18	2			25.6	11.6	37.2
F0011	1,956	53	8			24.9	10.0	34.9
F0013	371	152	2	4	34	91.0	17.8	108.8
F0014	47	16		1	5	45.9	20.0	65.9
F0015	386	156		3	2	61.8	12.9	74.7
F0016	8,418	1,519	337	1		65.7	11.8	77.5
F0017	4,073	853	46			65.6	11.5	77.1
F0018	610	95	11			70.7	11.0	81.6
F0019	1,467	410	4	3	13	69.5	12.4	81.9
F0020	14,444	3,164	247	752	657	49.4	17.9	67.3
F0021	5	1			6	96.0	53.8	149.8

MTCPM-1.2.4-292

Figure 3.10.13-16. Adjudicated Claims Throughput Analysis Report. This report provides a statistical summary on claims adjudication throughput over pre-defined time periods.

CDR19

The Contractor's solution shall track, store, and report claims paid based on configurable business rule (e.g. using a percent of billed charges with maximum allowable amounts for procedures, provider types, and participant demographics) per Agency defined criteria.

The evoBrix X Core Claims module tracks, stores, and reports claims paid based on configurable business rules (e.g. using a percent of billed charges with maximum allowable amounts for procedures, provider types, and participant demographics) per DPHHS-defined criteria. Our solution includes an extensible reporting model comprised of a structured set of data elements that are part of Claims Reporting and reference information (i.e., procedure rates, provider types, and provider demographics).

Our solution's ad hoc reporting capabilities rely on the underlying data model and its structures that store the relevant information on claims transactions, procedure rates, and provider types to produce essential reports based on configurable business rules.

CDR20

The Contractor's solution shall create, update, store, and maintain required and supplemental information to identify and group all claims transactions and non-claim transactions for completion of specified federal and state report (e.g. CMS-64, CMS-416 report,) per Agency defined criteria.

The evoBrix X Core Claims module creates, updates, stores, and maintains required and supplemental information to identify and group all claim and non-claim transactions to complete a federal and State report (e.g. CMS-64, CMS-416 report) per DPHHS-defined criteria. Our solution's data model is comprised of structures that needed to store and maintain all claims transactions and necessary supplemental reference information to support CMS-64 and CMS-416 reports. In addition, the Option A-Financial Module reporting capability also provides pre-defined reports (e.g., Federal Reporting Summary, Provider Group Expenditure) that provide insight and support CMS-64 and CMS-416 requirements.

CDR21

The Contractor's solution shall have the ability to generate a scheduled payment report on all Health Insurance Premium Payments (HIPP), as defined by the Agency.

The evoBrix X Core Claims module includes an extensible reporting model comprised of a structured set of data elements that are part of HIPP payment processing. Our solution relies on the underlying data model that stores the information related to HIPP day-to-day activities.

Our solution generates a scheduled payment report according to DPHHS layout requirements.

CDR22

The Contractor's Solution shall provide the capability to create, store, maintain CMS invoices and financial transaction summary reports, as defined by the Agency.

The Option A -Financial Module of evoBrix X Core Claims module includes the functionality to create, store, and maintain CMS invoices and financial transaction summary reports, as defined by DPHHS. Our solution's data model receives CMS invoices information from the System Integrator and then maintains the information in relevant data structures, which support ad hoc reporting through the extensible reporting model.

In addition, our solution includes a set of pre-defined reports (e.g., Provider Payment Summary, Payment Action, End-to-end FFS Claims Tracking) that provides detail on financial transactions at the summary or detail level.

CDR23

The contractors solution shall accept, store, and maintain current and historical provider data, per Agency defined criteria.

The evoBrix X Core Claims module accepts, stores, and maintains current and historical provider data per DPHHS-defined criteria. The Core Claims module requires provider data to process claims and can be integrated with the DPHHS provider system through the System Integrator by leveraging the evoBrix X Integration Gateway.

Team CNSI works with the DPHHS provider system vendor to define the file format and frequency required to receive provider information. We then use the ISR component to schedule, process, and load the file into our solution. We store and maintain the current and historical provider data in the Core Claims module. Users can access this information through the Provider Detail Application screen, as shown in Figure 3.10.13-17.

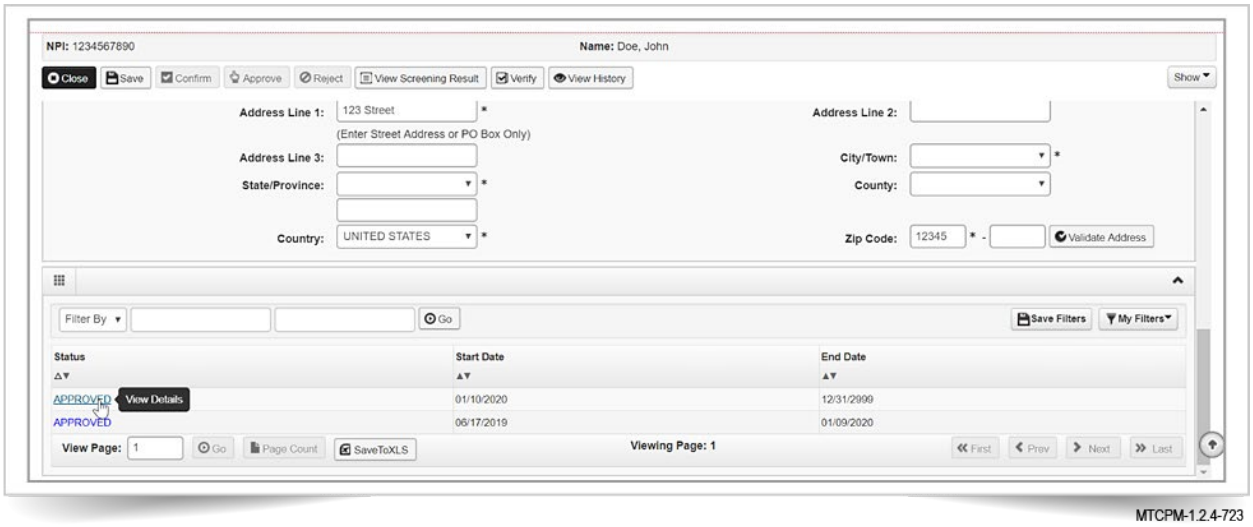


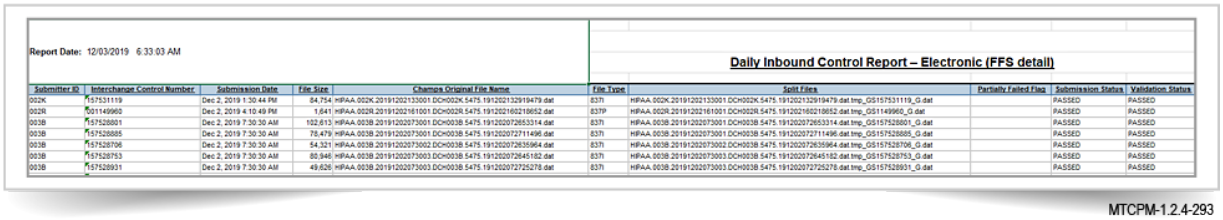
Figure 3.10.13-17. Provider Detail Application screen. Application screen that provides details on how provider demographic details are versioned in the underlying data model.

CDR24

The contractor's solution shall have the ability to maintain and store current and historical batch execution reports (e.g., claims, TPL, eligibility, PA, COBA), per Agency defined criteria.

The evoBrix X Core Claims module maintains and stores current and historical batch execution reports (e.g., claims, TPL, eligibility, PA, COBA), per DPHHS-defined criteria. Our solution includes a set of pre-defined batch execution and error reports (e.g., TPL Coverage Control, PA Request in Batch Verification Control, Daily Outbound Control, Daily Inbound Control, Error Code Count, Mass Batch Error) that detail current and previous batch executions for claims, PAs, eligibility etc.

Team CNSI has included a sample Daily Inbound Control Report in Figure 3.10.13-18.



Report Date: 12/03/2019 6:33:03 AM

Daily Inbound Control Report – Electronic (FFS detail)

Submitter ID	Interchange Control Number	Submission Date	File Size	Champs Original File Name	File Type	Split Files	Partially Failed Flag	Submission Status	Validation Status
002K	157531119	Dec 2, 2019 1:30:44 PM	84,754	HIPAA.002K.20191202133001.DCH002K.5475.191202132919479.dat	837I	HIPAA.002K.20191202133001.DCH002K.5475.191202132919479.dat.tmp_GS157531119_G.dat		PASSED	PASSED
002R	01149960	Dec 2, 2019 4:10:49 PM	1,641	HIPAA.002R.20191202161001.DCH002R.5475.191202160218652.dat	837P	HIPAA.002R.20191202161001.DCH002R.5475.191202160218652.dat.tmp_GS1149960_G.dat		PASSED	PASSED
003B	157526801	Dec 2, 2019 7:30:30 AM	102,613	HIPAA.003B.20191202073001.DCH003B.5475.191202072653314.dat	837I	HIPAA.003B.20191202073001.DCH003B.5475.191202072653314.dat.tmp_GS157526801_G.dat		PASSED	PASSED
003B	157526885	Dec 2, 2019 7:30:30 AM	78,479	HIPAA.003B.20191202073001.DCH003B.5475.191202072711496.dat	837I	HIPAA.003B.20191202073001.DCH003B.5475.191202072711496.dat.tmp_GS157526885_G.dat		PASSED	PASSED
003B	157528706	Dec 2, 2019 7:30:30 AM	54,321	HIPAA.003B.20191202073002.DCH003B.5475.191202072635964.dat	837I	HIPAA.003B.20191202073002.DCH003B.5475.191202072635964.dat.tmp_GS157528706_G.dat		PASSED	PASSED
003B	157528753	Dec 2, 2019 7:30:30 AM	80,946	HIPAA.003B.20191202073003.DCH003B.5475.191202072645182.dat	837I	HIPAA.003B.20191202073003.DCH003B.5475.191202072645182.dat.tmp_GS157528753_G.dat		PASSED	PASSED
003B	157528931	Dec 2, 2019 7:30:30 AM	49,626	HIPAA.003B.20191202073003.DCH003B.5475.191202072725278.dat	837I	HIPAA.003B.20191202073003.DCH003B.5475.191202072725278.dat.tmp_GS157528931_G.dat		PASSED	PASSED

MTCPM-1.2.4-293

Figure 3.10.13-18. Daily Inbound Control Report. Pre-defined report that displays the file status of HIPAA inbound files into the Core Claims module.

CDR25

The Contractor's solution shall provide a configurable report for all current and future approved HIPAA ASC X12 transactions from covered entities (e.g., health plans, health care clearinghouses, billing companies, trading partners, and health care providers) as defined by the Agency.

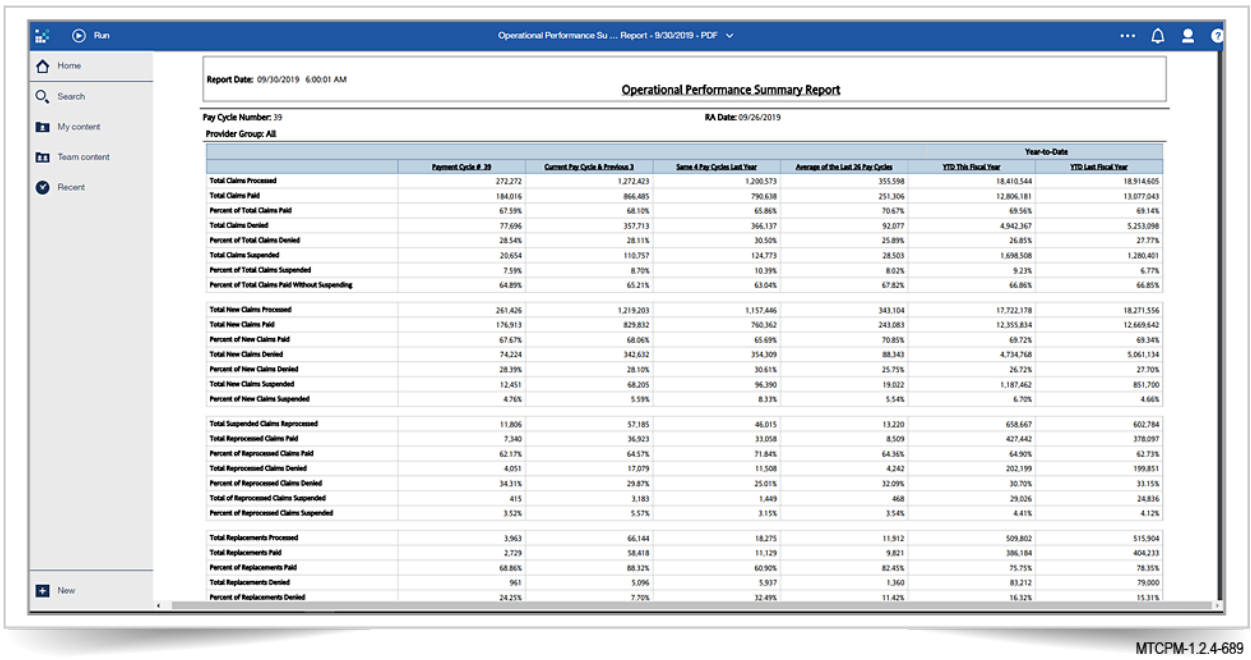
Team CNSI provides a DPHHS-defined configurable report for all approved current and future HIPAA ASC X12 transactions from covered entities (e.g., health plans, health care clearinghouses, billing companies, trading partners, and health care providers) through the evoBrix X Core Claims module. Our solution includes a set of pre-defined reports (e.g., Daily Outbound Control, Daily Inbound Control) that summarize all daily HIPAA claim transactions.

In addition, users can leverage the batch execution and ad hoc reports available through the extensible reporting model to gather summary and detail information on all HIPAA X12 transactions from covered entities.

CDR26

The Contractor's Ad hoc reporting solution shall have the ability to distribute weekly and monthly summarized databases views per Agency requirements.

The evoBrix X Core Claims module includes a comprehensive ad hoc reporting solution to allow authorized users to distribute weekly and monthly summarized database views per DPHHS requirements. Our solution includes a set of pre-defined metrics through evoBrix X HealthBeat analytics that provides summarized and detailed information on daily transactions, as shown in Figure 3.10.13-19. These metrics vary from daily, weekly, payment cycles: month-to-date (MTD) or year-to-date (YTD).



MTCPM-1.2.4-689

Figure 3.10.13-19. Operational Performance Summary Report. An informative pre-defined report that displays a summary of various claims transactions for a specific period of time.

In addition, we offer pre-defined reports that provide details on adjudication, operational performance, and payment summaries as well as an extensible reporting model that includes a structured set of data elements as part of Claims Reporting. The ad hoc reporting capability relies on the underlying data model and its structures that store the relevant information to produce DPHHS-required summarized data views.

CDR27

The Contractor's solution shall provide the capability to execute advanced reporting and analytics (e.g., aggregation of data, data modeling, forecasting) using all claims data to generate ad hoc reports as defined by the Agency

The evoBrix X Core Claims module includes functionality to execute advanced reporting and analytics (e.g., aggregation of data, data modeling, forecasting) using all claims data to generate ad hoc reports as defined by DPHHS. Our solution includes an extensible reporting model comprised of a standard structured set of data elements as a part of Claims and Financial Reporting, which offers transparency to project operations.

Our solution's data model can be leveraged to configure and provide an enhanced self-service user experience through ad-hoc reports according to DPHHS requirements. Authorized users can access aggregated data with different dimensions or the underlying detailed data to support critical day-to-day business activities. In addition, our solution's reporting capabilities include a set of pre-defined metrics provided through HealthBeat that provide summarized and detailed information on daily transactions. These metrics provide aggregation of data in various frequencies such as daily, weekly, payment cycle, MTD, and YTD.

The evoBrix X Core Claims module leverages the evoBrix X Operational Data Store (ODS) component to provide user access to transactional data for advanced reporting and operational decision-making purposes. Our solution provides flexible access to detailed data in a near real-time fashion so that users can access information in a timely manner. As a result, information remains continually up to date without overwhelming the transactional system that stores the fundamental data. The ODS also provides

self-service business intelligence (BI) capabilities through ad hoc reporting and visual analytics, which leverage dashboards with drill-up and drill-down.

The ODS sources "transactional" data from the evoBrix X Online Transaction Processing (OLTP) then makes the data available on a near-real-time basis for consumption through COGNOS self-service BI reporting processes. We designed our solution to account for every transactional change originating from the OLTP data mart to ensure full reconciliation while transitioning and transforming the data as it moves to the ODS. A few highlights of the ODS advanced reporting and analytics include:

- Support the needs of business and technical users to not only view data, but to intelligently inquire on it by slicing and dicing the data via multiple dimensions and hierarchies
- Provide multi-dimensional modeling capabilities to address the demanding needs of power users for analytic inquiries. This expands the cross-functional view of member enrollment, PAs, core claims, etc. data, and allows users to not only curate and correlate the data, but more importantly efficiently drill-up and drill-down to varying hierarchies to understand it
- Effectively offload data-intensive business functions (e.g., high-volume application inquiries, scheduled data extracts, or operational data requests) from the "core" transactional system

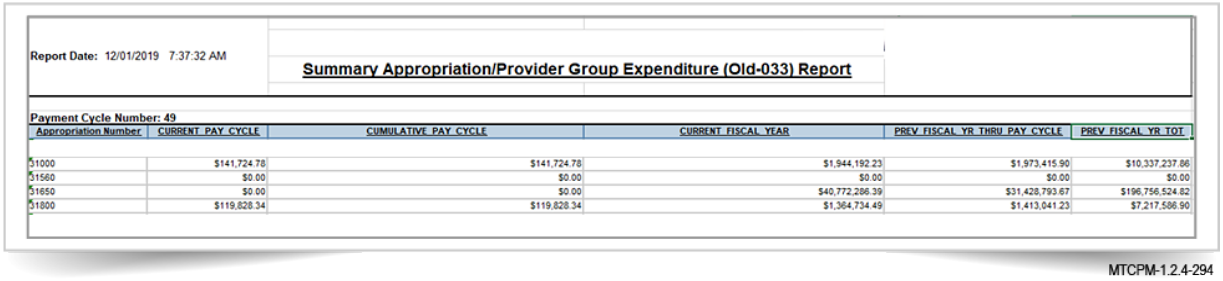
[redacted]

CDR29

The Contractor's solution shall have the ability to generate, store, and maintain reports on claim expenditures, as defined by the Agency (e.g. COS, Aid Category and claim type,).

The Option A – Financial Module of evoBrix X Core Claims module enables authorized users to generate, store, and maintain reports on claim expenditures (e.g. COS, Aid Category, and claim type), as defined by DPHHS. The Financial Reporting Module includes a set of pre-defined reports (e.g., Detail Appropriation/Provider Group Expenditure) that summarizes data from all expenditures for every Report Group processed on each payroll based on user parameters. In addition, users can leverage the extensible reporting model to provide an enhanced self-service user experience through ad-hoc reports according to DPHHS requirements. The reporting model relies on the underlying data model that can store and maintain information related to claim expenditures.

Team CNSI has included a sample Detail Appropriation/Provider Group Expenditure Report as Figure 3.10.13-21.



Report Date: 12/01/2019 7:37:32 AM

Summary Appropriation/Provider Group Expenditure (Old-033) Report

Payment Cycle Number: 49

Appropriation Number	CURRENT PAY CYCLE	CUMULATIVE PAY CYCLE	CURRENT FISCAL YEAR	PREV FISCAL YR THRU PAY CYCLE	PREV FISCAL YR TOT
01000	$141,724.78	$141,724.78	$1,944,192.23	$1,973,415.90	$10,337,237.86
01560	$0.00	$0.00	$0.00	$0.00	$0.00
01650	$0.00	$0.00	$40,772,286.39	$31,428,793.67	$196,756,524.82
01800	$119,828.34	$119,828.34	$1,364,734.49	$1,413,041.23	$7,217,586.90

MTCPM-1.2.4-294

Figure 3.10.13-21. Detail Appropriation/Provider Group Expenditure Report. A pre-defined report that provides a summary of pay cycle and cumulative group expenditures.

CDR30

The Contractor's solution shall have the ability to configure, track, maintain, store, and report claim and encounter lag (i.e., date of service to date of payment report measure), as defined by the Agency.

The evoBrix X Core Claims module can configure, track, maintain, store, and report claim and encounter lag (i.e., date of service to date of payment report measure), as defined by DPHHS. Our solution includes a set of pre-defined reports (e.g., Average Days from Date of Service to Date of Payment Trend, Average Days from Date of Service to TCN Date Trend, Prompt Payment, Prompt Payment - 30 Days, and Prompt Payment History) that provides insights on unpaid claims as well as the delay between the date of service and date of payment.

Team CNSI has included a sample Average Days from Date of Service Report as Figure 3.10.13-22.

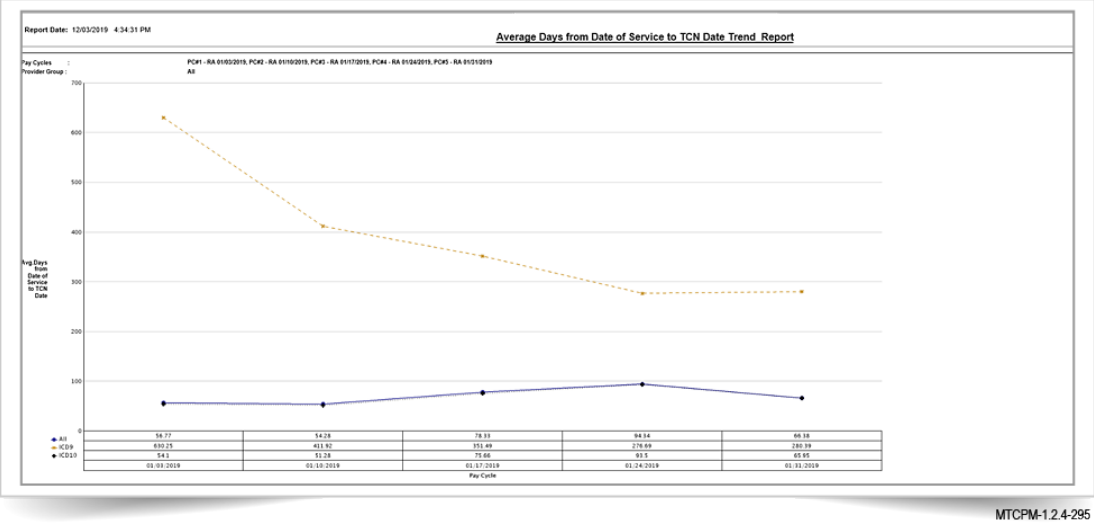


Figure 3.10.13-22. Average Days from Date of Service Report. Pre-defined, chart-based report that displays the trend of average days from a claim's service date to date of payment.

CDR31

The Contractor's solution shall collect, store, and maintain the data necessary for HEDIS reporting as required by CMS.

The evoBrix X Core Claims module data model consists of data structures designed to store all necessary information with respect to claims processing. The data model is segregated into various data marts that contain reference, metadata, and transactional information (e.g., provider, eligibility, claims, managed care capitation payments, benefits administration, prior authorization/utilization and common components), which support measures in HEDIS domains such as effectiveness of care, accessibility to care, utilization etc.

In addition, the data marts collect information from external entities through the System Integrator and the ISR solution. The data model. along with a sound data management strategy, enables Team CNSI to collect, store, and maintain data necessary to support HEDIS reporting requirements as required by the CMS.

CDR32

The Contractor's solution shall have the ability to generate reports on a schedule as defined by the Agency.

The evoBrix X Core Claims module can generate reports on a DPHHS-defined schedule. Our solution includes a set of pre-defined reports, which Team CNSI can schedule for execution according to DPHHS-defined frequencies. In addition, users can create and schedule their own reports using ad hoc reporting under the extensible reporting module. Team CNSI has included a sample Report Schedules page within the COGNOS Analytics workspace as Figure 3.10.13-23.

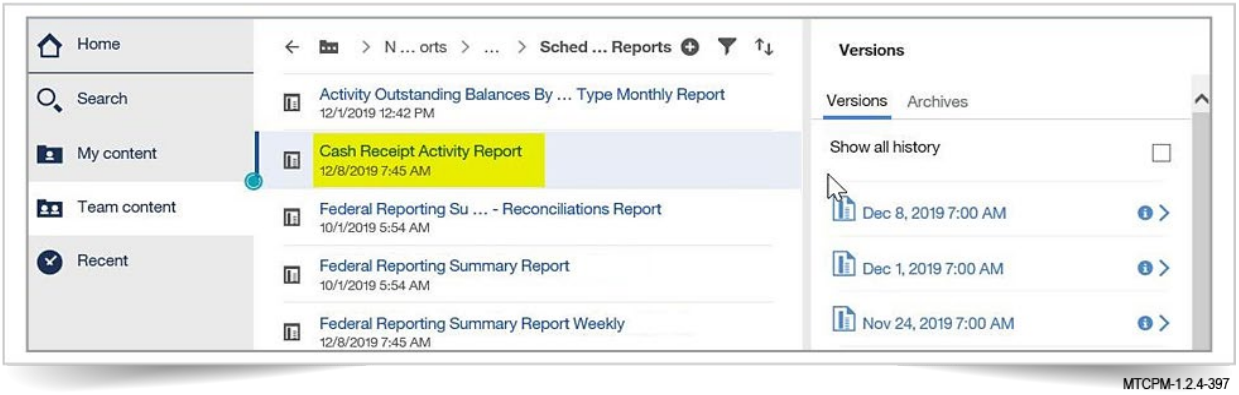


Figure 3.10.13-23. Scheduling a report. COGNOS BI reports properties page displaying the options to schedule reports.

CDR33

The Contractor's solution shall have the ability to modify system generated (i.e. canned reports) reports as defined by the Agency.

The evoBrix X Core Claims module allows users to modify system-generated reports (i.e. canned reports) as defined by DPHHS. Our solution includes a set of pre-defined reports, which we can modify according to DPHHS requirements. Team CNSI has included a sample COGNOS Analytics workspace as shown in Figure 3.10.13-24.

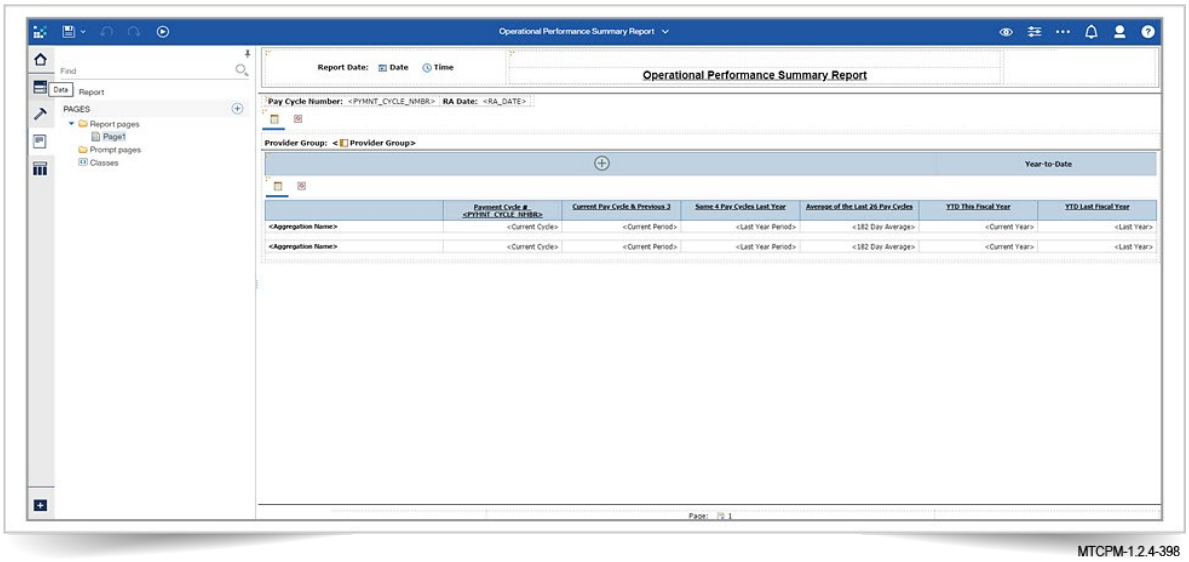


Figure 3.10.13-24. COGNOS Analytics Workspace. This sample screenshot depicts how authorized users can modify canned reports from this workspace.

CDR47

The Contractor's solution shall have the ability to transmit data directly to other entities (e.g. actuaries) as defined by the Agency.

Team CNSI's evoBrix X solution's Integration Gateway supports automated data exchanges with various Medicaid business process areas and interface partners. As such, we can send and receive DPHHS-

defined reports to these external entities. The Integration Gateway includes the following components to share data:

- Integration Gateway components:
  - File/EDI Gateway – This component leverages Oracle's Service Oriented Architecture (SOA) Managed File Transfer (MFT) to securely receive and send files to the external systems. This architecture helps us to integrate seamlessly with the MPATH System Integrator to enable the loose coupling.
  - API Gateway – This component leverages the industry-leading Oracle SOA tool to produce and consume real-time web services with the external systems. This allows for easy integration with the MPATH System Integrator.
- Technical components
  - Interface Service Repository (ISR) – This component uses an enterprise-class service bus (Oracle SOA Suite) as the core orchestration tool of business processes across the different applications that support Medicaid operations. The evoBrix X CPMS solution supports scheduling, audit, error logging, and escalation features. It also supports detailed reporting on interface execution status, combined with notification modules to track execution of the various interface transactions thus ensuring processing of interfaces within timeframes.
  - EDI Translator and Validator – This component uses Edifecs to validate and translate all EDI transactions to ensure all HIPPA files adhere to applicable standards.

Technical Services-Web Service Framework – This component supports SOAP or REST as a protocol for producing or consuming web services for external agencies. In addition, the framework leverages industry-standard Apache CXF libraries. The API specification for SOAP services follows the Web-Services Definition Language (WSDL) standards. The REST Open API specification is also called Swagger Specification.

CDR34

The Contractor's solution shall have the ability to send and receive reports from external entities, as defined by the Agency.

The evoBrix X Core Claims module sends and receives DPHHS-defined reports from external entities via email and stores them in the content store where authorized users can access the output files. The Reporting module can also interact with the evoBrix X Enterprise Content Management (ECM) to store and transmit report files. At the same time, our solution can receive external report files via the System Integrator either using interfaces in the form of flat files to be staged in evoBrix X or stored directly into the evoBrix X ECM solution. Figure 3.10.13-25 depicts how the evoBrix X ECM solution ingests documents from external entities.

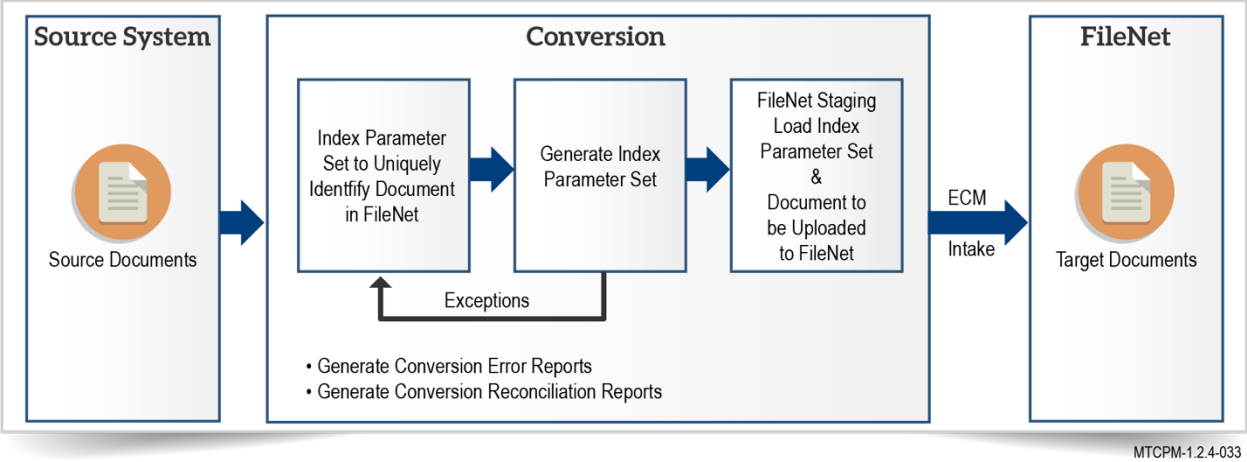


Figure 3.10.13-25. Document Conversion Process. Our solution ensures that all required source documents are converted, and accounted for, in Team CNSI's ECM (FileNet) solution.

CDR35

The Contractor's solution shall provide workflow access, assignments, routing of applicable reports and execution for all essential aspects of the business processes (e.g., service authorization, managed care, provider screening, client communications), as defined by the Agency.

The evoBrix X Core Claims module processes work queues for all essential aspects of DPHHS-defined business processes in real-time. Our solution assigns tasks, sends notifications, routes applicable reports, and provides escalation to management and/or supervisors for Claims Resolution Work Assignments, Prior Authorization Request Work Assignments, etc.

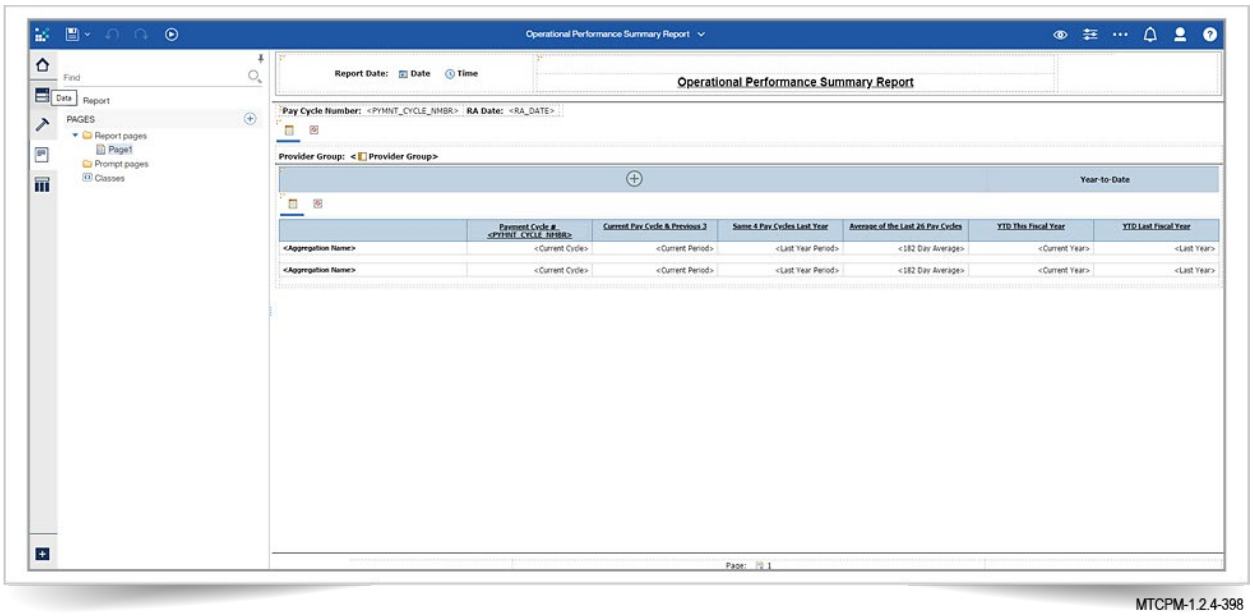
Authorized users can view their task item in the task list page within our solution and then act upon the task accordingly.

CDR36

The Contractor's solution shall have the ability to select which data elements appear on provider reporting or remittance advices (e.g. claims exceptions codes that are information only or are set to pay), as defined by the Agency.

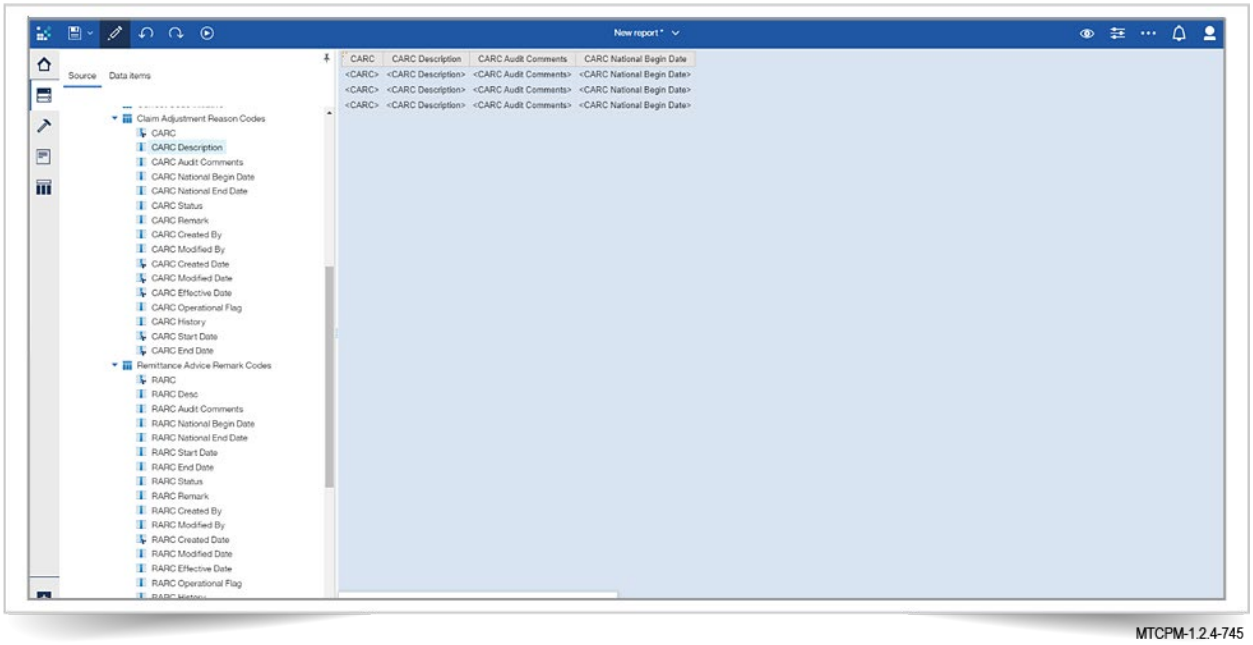
The evoBrix X Core Claims module includes the functionality to select the data elements that appear on provider reporting or RAs (e.g. claims exceptions codes that are information only or are set to pay) as defined by DPHHS. Our solution includes an extensible reporting model comprised of a standard structured set of data elements, as described throughout this proposal section. Our reporting model helps to create and maintain transparency into MPATH project operations. Users can leverage it to develop ad hoc reporting that enables them to select the elements needed for provider or RA reporting, according to DPHHS requirements.

Team CNSI has included a sample COGNOS Analytics workspace as shown in Figure 3.10.13-26. We have also included a screenshot of the ad hoc reporting model that contains claims transactions and payment related subject area within the COGNOS Analytics workspace as shown in Figure 3.10.13-27.



MTCPM-1.2.4-398

Figure 3.10.13-26. COGNOS Analytics Workspace. This sample screenshot depicts how authorized users can modify canned reports from this workspace.



MTCPM-1.2.4-745

Figure 3.10.13-27. COGNOS Analytics Workspace reports. Users can run reports in the workspace using pertinent query information.

CDR37

The Contractor shall support TPL requests from the Agency related to tracking and reporting cost avoidance dollars.

The evoBrix X Core Claims module supports DPHHS TPL requests related to tracking and reporting cost avoidance dollars. Our solution is comprised of data structures relevant to storing and maintaining cost share information associated with claims. While addressing TPL requests from DPHHS, our solution can

leverage the Claims Reporting ad hoc model that relies on the data mart to extract cost share information, according to DPHHS requirements.

CDR38

The Contractor's solution shall allow for users to generate notifications/alerts in addition to the scheduled notifications/alerts based on configurable business rules.

Our solution's framework provides a consistent approach to meet all DPHHS notification needs. Authorized users can generate notifications/alerts as well as schedule notifications/alerts through the online screen "My Inbox." Users can view their notification items in the list page in our solution and then subsequently act upon the task. The framework ensures that all information and event notifications include aggregated and integrated information and are consistent across the evoBrix X CPMS solution. All notifications/alerts are based on configurable business rules.

CDR39

The Contractor's solution shall provide automatic and ad hoc reporting related to the day to day activities of the HIPP program (e.g., Active Case List Report, Counts by Health conditions Report, Payment History by Month Report, Referral Summary Report, Cost Effectiveness Report, Cost Effectiveness evaluation Report, Housecleaning Status Report, Review Date Report, All Status Report, County Status Report) as defined by the Agency.

The evoBrix X Core Claims module includes an extensible reporting model that includes a structured set of data elements that are part of HIPP payment processing. Our solution relies on an underlying data model that stores information related to HIPP day-to-day activities. We can implement scheduled reporting that reflects day-to-day HIPP activities according to DPHHS-defined schedules. In addition, ad hoc reporting helps users design and execute their own reports according to DPHHS data needs.

CDR40

The Contractor's solution shall allow for more than one template for remittance advices based on configurable business rules.

The evoBrix X Core Claims module provides a correspondence framework to generate RAs in PDF format. Our solution generates the paper RA on a weekly basis and reports all processed claims during the pay cycle. Our solution generates the paper RA at the NPI level and archives it in the evoBrix X ECM module with appropriate index parameters for easy retrieval. The correspondence framework can configure multiple templates and generate RAs according to State business rules. Authorized users can search all the correspondences and retrieve the appropriate RA using the portal.

CDR41

The Contractor's solution shall produce, store, and transmit an image of each remittance advice as defined by the Agency.

The evoBrix X Core Claims module produces, stores, and transmits an image of each RA as defined by DPHHS. Our solution generates RAs in PDF and HIPAA 835 formats for paid and denied claims and includes standard claim adjustment reason and claim payment remark codes. The solution associates all denial reasons to a claim as part of adjudication and as part of the RA. Our solution archives the RAs, and business users can access them through the application screens. RAs can also be shared through the correspondence framework.

CDR42

The Contractor's solution shall allow authorized users to modify report templates (e.g., Remittance Advice) as defined by the Agency.

The evoBrix X Core Claims module allows authorized users to modify report templates (e.g., Remittance Advice) as defined by DPHHS. Our solution includes an extensible reporting model comprised of a standard structured set of data elements that leads to operational transparency. Users can leverage this model to develop ad hoc reporting, which allows them to select the reporting elements needed for RA reporting templates, according to DPHHS requirements.

Team CNSI has included a sample COGNOS Analytics workspace as shown in Figure 3.10.13-28.

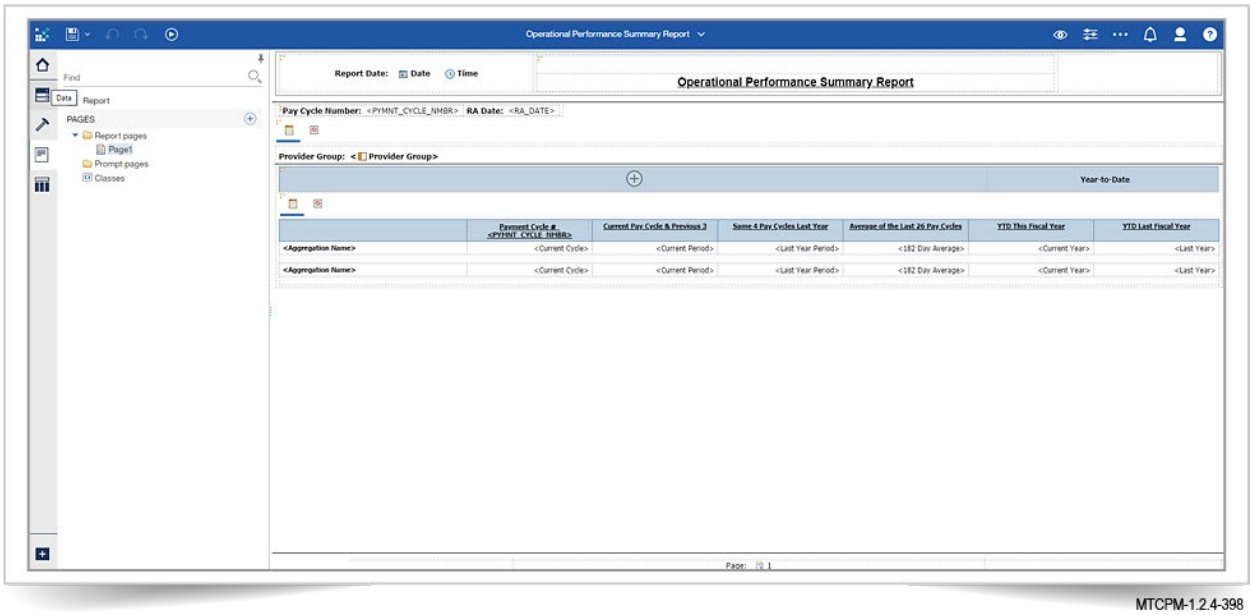


Figure 3.10.13-28. COGNOS Analytics Workspace. This sample screenshot depicts how authorized users can modify canned reports from this workspace.

CDR43

The Contractor's solution shall support and maintain a current and history of remittance advices that are searchable and viewable for authorized users, per Agency defined criteria.

The evoBrix X Core Claims module supports and maintains a current snapshot as well as a history of RAs for authorized users to search and view, per DPHHS-defined criteria

Our solution's data model is comprised of structures that are relevant to storing and maintaining current and historic RA information. Our solution also includes an extensible reporting model comprised of a standard structured set of data elements. As such, users can develop ad hoc reporting to add filter criteria that enables them to provide specific RA details to obtain necessary information.

CDR46

The Contractor's solution shall have the ability to produce the Abortion Listing report as specified by Agency.

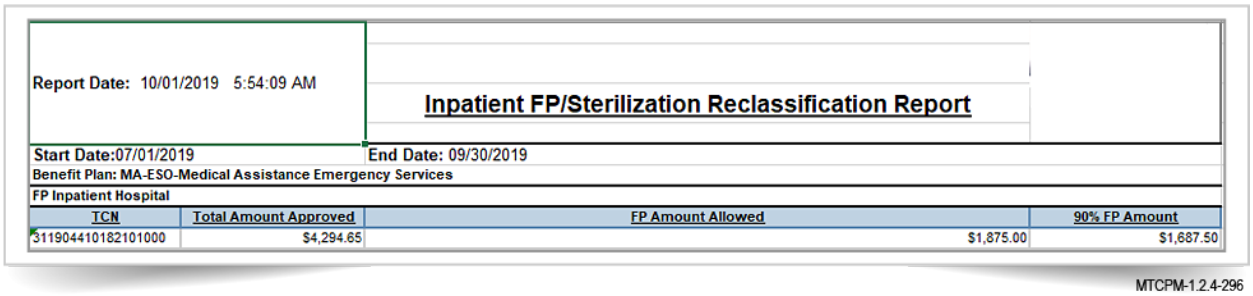
The evoBrix X Core Claims module includes the functionality to produce the Abortion Listing Report as specified by DPHHS. Our solution's data model is comprised of structures relevant to storing and maintaining claim transactions related to all procedures. The Core Claims module also includes an extensible reporting model, which users can use to develop ad hoc reports associated with abortions, as required.

CDR45

The Contractor's solution shall have the ability to produce the Inpatient Sterilization Claims (Excluding C-Sections) report as specified by Agency.

The evoBrix X Core Claims module can produce an Inpatient Sterilization Claims (Excluding C-Sections) Report as specified by DPHHS. Our solution includes a set of pre-defined reports (e.g., Inpatient FP Sterilization Reclassification) that identify FP/sterilization expenditures associated with inpatient hospitalizations, which identify the amounts billable to CMS.

Team CNSI has included a sample Inpatient FP Sterilization Reclassification Report as Figure 3.10.13-29Figure 3.10.13-29Figure 3.10.13-29.



Report Date: 10/01/2019 5:54:09 AM

Inpatient FP/Sterilization Reclassification Report

Start Date:07/01/2019 End Date: 09/30/2019

Benefit Plan: MA-ESO-Medical Assistance Emergency Services

FP Inpatient Hospital

TCN	Total Amount Approved	FP Amount Allowed	90% FP Amount
311904410182101000	$4,294.65	$1,875.00	$1,687.50

MTCPM-1.2.4-296

Figure 3.10.13-29. Inpatient FP Sterilization Reclassification Report. This sample screenshot depicts a pre-defined report that shows details of FP claims.

CDR44

The Contractor's solution shall have the ability to produce the Payments for Sterilization and Hysterectomies report as specified by Agency.

The evoBrix X Core Claims module enables authorized users to produce payments for the State-specified Sterilization and Hysterectomies Report. Our solution's data model is comprised of structures that are relevant to storing and maintaining sterilization expenditure information. Our solution also includes an extensible reporting model, which users can use to develop ad hoc reports associated with sterilization and hysterectomies.

CDR48

The Contractor's solution shall receive and store claims processing and payment information by service category or provider type to analyze timely processing of provider claims according to requirements (standards) in 42 CFR 447.45.

The evoBrix X Core Claims module receives and stores claims processing and payment information by service category or provider type to analyze timely processing of provider claims according to requirements (standards) in 42 CFR 447.45. Our solution's data model includes structures that are relevant to storing and maintaining all claim transactions. The stored information includes, but is not limited to, provider, diagnosis, and service. As a result, our solution's data model favors grouping or analyzing data based on category of service and/or provider type.

The evoBrix X Core Claims module also includes a set of pre-defined reports (e.g., , Prompt Payment, Prompt Payment History, Average Days from Date of Service to Date of Payment Trend) that provide summary and/or detailed information on timely payment of claims to support compliance with 42 CFR 447.45.

In addition, authorized users can leverage an available extensible reporting model comprised of a standard structured set of data elements, which creates an enhanced self-service user experience through ad-hoc reports according to DPHHS requirements. The reporting model relies on the underlying data model to provide information in support of 42 CFR 447.45 compliance.

CDR49

The Contractor's solution shall maintain reporting services that are backward compatible, and the reports functionality is preserved over major or minor releases or the contractor will provide migration support to move reports forward.

The evoBrix X Core Claims module maintains reporting services that are backward compatible. Our solution preserves its reports functionality over major or minor releases; if not, Team CNSI provides migration support to move reports forward. We closely align our solution's reporting enhancements with—and Team CNSI follows—operational release processes. All components tied to reports (pre-built reports and ad hoc models) and report functionality are version maintained and can be reverted in conjunction with the corresponding operational release rollback. This ensures that once we have defined a report and it becomes a part of operations, we maintain its integrity through software changes including, but not limited to, upgrades, patches, fixes, defect corrections, and enhancements.

CDR50

"The Contractor's solution shall support payment reimbursement methodology research, analysis and development by providing expenditure data through service codes including but not limited to:

-healthcare common procedure coding system (HCPCS), current version

-international classification of diseases (ICD), clinical modifier, current version

-national drug code (NDC), current version"

The evoBrix X Core Claims module includes structures that are relevant to store and maintain up-to date reference data including, but not limited to, ICD, HCPCS, NDC and HCPCS-NDC crosswalk information from sources such as PBMS. The pre-defined and ad hoc reporting designed on the underlying data model, uses the reference data as measures and associate the corresponding claims and payment information to analyze, drill down, and summarize the transactional information to a dimension level as

per DPHHS requirements to support payment reimbursement methodology research, analysis, and development. Figure 3.10.13-30 illustrates where authorized users can create new reports.

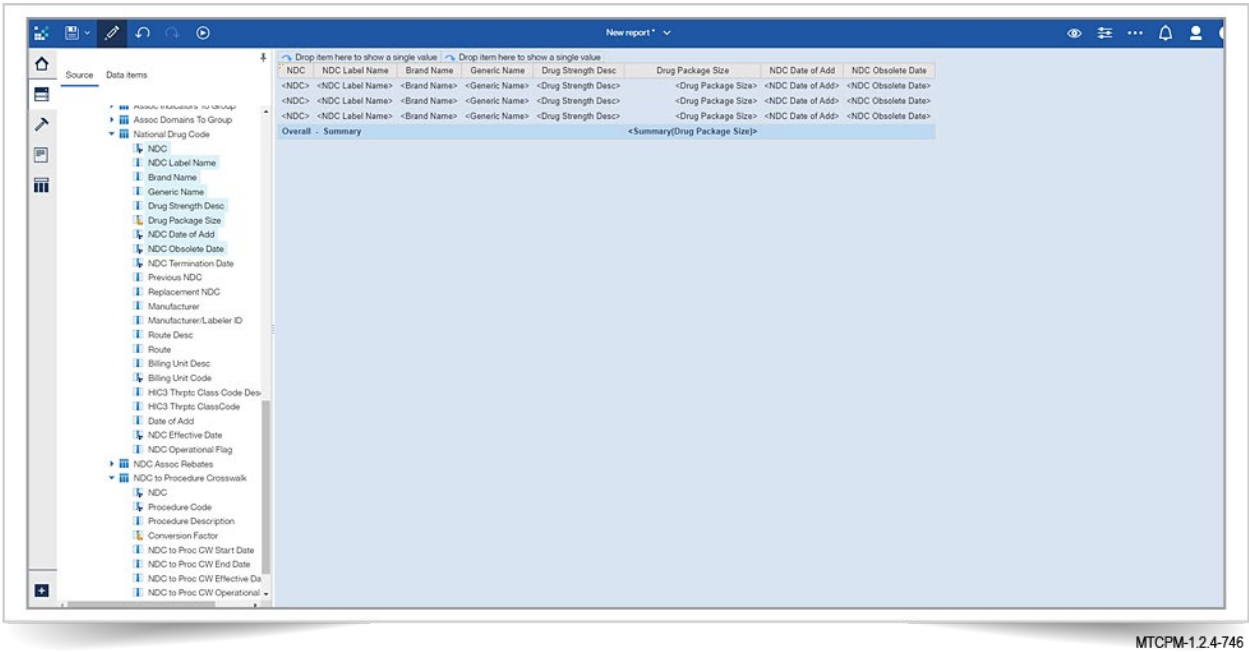


Figure 3.10.13-30. COGNOS Ad hoc Benefits Administration package. COGNOS reference ad hoc model where users can leverage NDC and NDC procedure crosswalk information to create a new analysis/report.

CDR51

The Contractor shall develop a repayment schedule for the payee in coordination with the Agency in circumstances where there are insufficient claims or payee funds to satisfy recoveries within 75 days upon detection of an overpayment.

Team CNSI collaborates with DPHHS to develop a repayment schedule for payees in circumstances where there are insufficient claims or payee funds to satisfy recoveries within 75 days following the discovery of an overpayment. The Option A - Financial module of evoBrix X Core Claims provides payment plan (installment) functionality so users can manually create payment plans for ARs with a balance. This allows payees to pay back the balance by an appropriate amount with a specific due date assigned for each installment per the schedule created for the repayment.

CDR52

The Contractor shall recover all overpayments within 30 calendar days from detection of an overpayment.

Team CNSI recovers all overpayments within 30 calendar days following detection by applying one of the following methods that are part of the Option A – Financial Module of evoBrix X Core Claims:

- AP/AR Netting: This is a process by which we can recoup overpayments automatically by offsetting the balance against future claim payments. Team CNSI can configure rules regarding how AP/AR Netting should occur (i.e., offsetting against an overpayment belonging to the same Provider or Tax ID or within the same program).

- Cash Receipt Application: The evoBrix X Financial Management module provides cash receipt functionality. All checks are entered and stored in the Accounts Receivable module. Checks are identified by the provider number and can be applied against any outstanding payee AR.
- Manual Adjustments: The evoBrix X Financial Management module enables users to manually adjust AR balances. Team CNSI also allows supervisors to review the adjustments and approve or reject them based on user responsibilities configured in our solution.

3.10.14 System Administration and Operations

This section addresses requirements related to the overall operations of the claims solution. The solution will act as the Electronic Data Interchange (EDI) gateway to process all inbound and outbound HIPAA mandated X12 compliant transactions and Trading Partner management.

In addition, the solution must provide a self-service portal with enhanced web-based capabilities to support the following:

- *on-line real-time transactions processing and direct data entry for claims*
- *claim status inquiry*
- *batch upload, download, view and print HIPAA transactions*
- *submission and retrieval of documents*
- *secure messaging*
- *help-desk functions.*

The System Administration and Operations section also includes requirements for change management including the creation of tickets and tracking of requests through implementation. The offeror must describe how the solution will be continuously maintained, enhanced, and modified to ensure compliance with new Federal and State regulations and mandates, healthcare delivery models, and to support interoperability with all other data sharing entities. The Offeror must describe in detail their approach to meet each of the System Administration and Operations requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Team CNSI's evoBrix X CPMS solution offers users and providers with an intuitive web interface and Electronic Data Interchange (EDI) gateway to efficiently and quickly submit, review, and monitor all inbound and outbound claims transactions. Providers have varying requirements and differing levels of technical capabilities to submit claims. Through the evoBrix X CPMS solution, providers are offered a range of functional capabilities to submit and review submitted claims efficiently based on their specific needs and preferences. The system accommodates claims intake through several different mechanisms. Team CNSI will establish connections with trading partners for receiving and validating EDI claims directly. Established trading partners can upload a file in X12 5010 format using the Web Portal or can exchange the EDI files through Business-to-Business (B2B) file exchange process. Upon receipt, all claims go through a validation process for compliance with the accepted EDI standards and SNIP guidelines. Our evoBrix X CPMS solution provides user-friendly interfaces and supporting business operations to support all activities related to claims submission, review, adjustment, monitoring, and reporting. The evoBrix X web portal allows for:

The Team CNSI Advantage

Team CNSI's System Administration and Operations tools and processes are based on best practices derived from over a decade of experience operating Medicaid systems with 300 million claims submitted annually from 25,000 unique trading partners for roughly 290,000 providers.

- Standards-based EDI gateway enables secure exchange of HIPAA files
- Online entry of HIPAA compliance claims reduces administrative burden for providers with powerful capabilities using claims submission templates
- ITIL-based service request processes using Jira provide full lifecycle tracking of all requests from submission to acceptance
- Configuration and rules-driven approach reduces operational risk and enables rapid compliance with changing policies and regulations

MTCPM-1.2.4-855

- On-line, real-time transaction processing including:
  - Direct data entry (DDE) and 837 file uploads;
  - Paper claims submission; and
  - Batch submission through the electronic data interchange (EDI) Gateway.
- Claim status inquiry
- Batch upload, download, view and print HIPAA transactions
- Submission of and retrieval of documents
- Secure Messaging (available as a solution element of Option B)

- On-line help-desk functions including user self-help and the ability to request service support

Our claims intake solution has been operational in several states for over a decade. It has been designed to receive, store, process, and pay institutional, dental and professional claims by applying appropriate edits and pricing methodologies in the Medicaid environment, regardless of the input method applied. Daily audits and reporting mechanisms are established to track the claims throughout the adjudication life cycle.

Team CNSI has received and adjudicated over 300 million claims annually. Today, we collect claims submitted by 25,000 unique trading partners, representing roughly 290,000 providers across multiple Medicaid state implementations. Throughout our decades of EDI support experience, we have tailored EDI processes that reduce implementation risk and improve provider satisfaction. We have done so by:

- Including an EDI testing phase prior to Operational go-live;
- Enabling providers and their trading partners to confirm file errors prior to submission; and
- Ensuring providers experience no disruption in payment receipt.

In addition to enabling claims intake and processing through a variety of mechanisms, Team CNSI offers a comprehensive operations and maintenance approach to provide continuous improvement of the system through a formalized process of change management. Team CNSI adheres to best practices for change and configuration management as defined by PMBOK and as applied through our ITIL service management framework. Change control is applicable to any change that affects approved deliverables or contractually defined project scope, budget, or scheduled completion dates. As part of our Planning activities in the first Phase of DDI, Team CNSI will leverage our Change and Configuration Management Plan template to create a plan specific to the State of Montana CPMS project. This plan defines the change control process, workflow, tracking, stakeholders, tools, expectations and other requirements as defined and agreed to in collaboration with DPHHS. After the baselines for scope, contract milestone/deliverable dates, and budget have been established, all changes affecting these project baselines are managed using the change control process described in this plan or the defect management processes as described in the Master Test Plan (MTP). As with other project processes, the change control practice is a living process that is updated as appropriate throughout the project.

Team CNSI is strategically focused on providing Medicaid solutions and services – this is our core business and our primary focus. We maintain a knowledge base of state and federal standards and regulations to ensure our solutions and services are in compliance and meet the latest requirements for healthcare IT functionality, interoperability, and data sharing. Team CNSI continually conducts research and analysis of regulatory and policy changes that impact Medicaid solutions. We also participate in industry conferences to monitor trends and engage in discussions with state and CMS staff. Moreover, the depth of our research, knowledge, and awareness enables us to envision the upcoming changes and work closely with the Agency to be prepared and plan for the changes proactively instead of reacting to change. Our approach to regulatory compliance begins from day one by itemizing all controls; safeguards, applicable local and federal regulations, such as all Federal Information Security Management Act (FISMA) and Health Insurance Portability and Accountability Act (HIPAA) regulations, and all applicable DOD, OMB, and NIST standards. Changes to standards and regulations during implementation and operations will be conducted through the approved change management process. This will enable Team CNSI and the Agency to maintain configuration control and systematically analyze and review impact to changes on system configuration baselines.

SAO01

The Contractor shall establish and maintain an automated reconciliation of all electronic claims received and provide a dashboard with daily aggregate summary and the ability to drill down by specific trading partner, billing provider, transaction type (e.g., 837I, 837P, 837D, encounter) and search capabilities using all available data elements to validate all transactions received are processed according to Agency defined business rules.

The evoBrix X Core Claims module provides an automated reconciliation of all electronic claims received. The system captures and maintains details of each claim including, but not limited to, trading partner, billing provider, and transaction type. The system has a robust reporting capability that enables both searching on different fields and values (configurable to meet the State's requirements) and provides a set of predefined activity tracking reports, such as claims currently in processing, aging claims suspended, adjudication throughput analysis, and dashboards to proactively monitor the claims status. Timely alerts trigger prompt actions by operations staff, enabling them to avoid potential backlogs throughout the claim life cycle. Our solution provides a holistic view of claims operations through our HealthBeat tool to ensure accurate reporting and alignment with SLAs. In addition to the HealthBeat dashboard, the evoBrix X Core Claims module also generates daily reports to provide statistics of all the electronic claims received. Figure 3.10.14-1 and Figure 3.10.14-2 shows various HealthBeat dashboard views activity tracking.



Figure 3.10.14-1. HealthBeat Dashboard View. HealthBeat provides a set of predefined activity tracking reports to proactively monitor the claims status.



Figure 3.10.14-2. HealthBeat HIPAA Transactions Dashboard. HealthBeat provides a set of predefined activity tracking reports to proactively monitor the claims loading, remittance advise and transactions aging details.

SAO02

The Contractor shall provide staff to develop, organize, lead, and conduct training and education activities (e.g., provider and Agency staff training) as defined by the Agency.

[redacted]

Detailed information on our staffing approach has been included in Attachment H, Resource Allocation.

SAO03

The Contractor's solution shall provide flexible publishing capabilities (e.g., formatting and stylistic consistency, allow control of format, font, graphics, layout, and page design, allow creation of master pages and style sheets to automate and structure documents, utilize industry standard tools to assure proper spelling, punctuation, grammar, capitalization, and checks for technical compliance with printing industry standards before publication) as defined by the Agency.

Team CNSI's documentation standard includes a corporate Style Guide based on the *Chicago Manual of Style.* The CNSI Technical Writing team adapts the Style Guide to conform to the specific requirements of each client and project. This provides for consistency of spelling, punctuation, grammar, and capitalization. In addition, Team CNSI uses a collection of standard Microsoft Word style templates that are also adapted to conform to the specific requirements of each client and project. The use of these templates and standardized master pages ensure that format, font, layout, and page design are consistent throughout the life cycle of the project. This provides for consistency of style, format, and compliance with printing industry standards. Team CNSI uses a centralized graphics team and a set of base graphics that have been thoroughly vetted to provide consistency of appearance and format.

SAO04

The Contractor shall provide flexible publishing capabilities for multi-chapter publications and large technical documents (e.g., generate and insert footnotes and endnotes, generate table of contents, generate indices, include appendices, manage chapter files, manage centralized style sheets, manage tabular material, import tables from various data sources into controlled table structures) as defined by the Agency.

Team CNSI uses a collection of standard Microsoft Word style templates that are adapted to conform to the specific requirements of each client and project. The use of these templates allows for the automatic generation of footnotes, endnotes, tables of contents, indices, and tables. These style templates also allow for quick, precise, and correct management of chapter files and importing of data into tables.

SAO05

The Contractor shall provide flexible publishing capabilities to allow for control over all typographical characteristics (e.g., leading and kerning) and support for full color output as defined by the Agency

Team CNSI uses a collection of standard Microsoft Word style templates that are adapted to conform to the specific requirements of each client and project. The use of these templates allows for precise control of typographic characteristics to ensure consistency and readability. Team CNSI uses a standardized color template that works with all major displays, monitors, printers, and other devices.

SAO06

The Contractor's solution shall provide a ticket (e.g., customer service request, state task request) dashboard to include, but not limited to: request, design, analysis of change (e.g., level of effort, schedule, resources), ticket type (e.g., Enhancements, Deficiencies, Maintenance, Research, Configuration and Mass Adjustments), test, implement, and approval and provide a detailed and viewable status of all ticket requests (including linking related tickets) from receipt through approval as defined by the Agency.

Team CNSI uses Atlassian Jira for logging and tracking service and task requests. Approved Team CNSI business teams, DPHHS, and third-party users can log requests directly into Jira via the web interface. Jira supports incoming requests, enhancements, deficiencies, maintenance, research, configuration and mass adjustments. Every ticket generated by the system has persistence or "history" showing what happened to the ticket within its life cycle. Jira is a multi-user system, which means that multiple users may work simultaneously on tickets, reading incoming messages, and updating them. Jira is highly scalable, capable of handling thousands of tickets per day, and can handle a large number of users working simultaneously.

SAO07

The Contractor shall create and maintain a communication inventory (e.g., letter, email templates) with necessary information (e.g., content, stakeholders) to communicate specific events (e.g., system or staff change) and develop appropriate communication and notifications for stakeholders as defined by the Agency.

Team CNSI will create and maintain an inventory of all communication items within the project SharePoint repository. Based on our experience providing correspondence and communications in other states, we have an existing library of templates that may be reusable for Montana. As part of our solution sessions during DDI, our team will review existing templates with DPHHS to determine what can be reused and what new templates will need to be created. If DPHHS as existing templates, these will be immediately added to the library for continued use to maintain consistency.

SAO08

The Contractor's solution shall provide for the creation and processing of online surveys, store indexed survey results (e.g., survey number, date, topic, response date) and provide the results and supporting data of online surveys to authorized users as defined by the Agency.

Team CNSI's evoBrix X CPMS solution supports survey setup through configurable business rules. The evoBrix X platform that powers the solution comes with a Generic Questionnaire Module (GQM), a framework component, that enables State users to setup questions and control the path of questionnaire based on run-time response selection. The solution also supports versioning of questions by tracking the history of changes. The automated email functionality of the evoBrix X correspondence module will be configured and customized based on DPHHS-defined business rules to generate invitations to appropriate stakeholders as soon as a survey set up is completed. The surveys are accessed and directly responded to from notifications received in the user's inbox. The contents of the survey are configurable based on state-specific requirements and business rules. The evoBrix X solution supports collecting the responses and analyzing the data. The analyzed data will be presented to authorized users. Figure 3.10.14-3 provides a sample survey functionality developed using our survey framework capability.

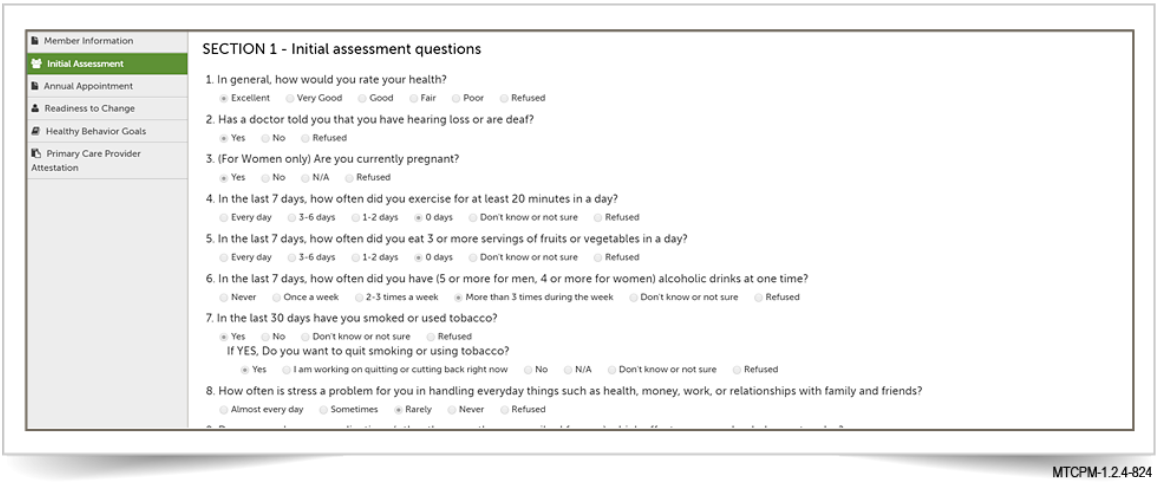


Figure 3.10.14-3. Survey Sample. Team CNSI's solution includes an integrated survey design and implementation capability.

SAO09

The Contractor shall supply staff to meet all service level agreements and perform all claims processing functions (e.g., claims supervisor, claims processing staff, quality assurance staff, publication staff, training staff) as defined by the Agency.

Team CNSI performed a detailed analysis of all solicitation documentation including the Request for [redacted]

Detailed information on our staffing approach has been included in Attachment H, Resource Allocation.

SAO10

The Contractor shall supply staff to analyze, develop, configure, and maintain all claims pricing and payment methodologies (e.g., claims processing updates, payment methodology updates, Federal and State policy guideline changes, ad hoc impact analysis, changes with third party tools) as defined by the Agency.

Team CNSI performed a detailed analysis of all solicitation documentation including the Request for [redacted]

Detailed information on our staffing approach has been included in Attachment H, Resource Allocation.

SAO11

The Contractor must receive approval from the Agency to make any changes to the system (e.g., applications, programs, procedures, specifications, parameters, disposition codes, definitions or objectives.) In the event that an emergency system change is required to continue normal system operations and the Contractor is unable to obtain Agency approval for the change, the Contractor must notify the Agency as soon as the change is made and the system returns to normal operations using the communication process as defined by the Agency.

Appropriate change control is a key factor in containing costs, managing resources, and ensuring the project is executed according to defined and agreed-upon baseline specifications. Any changes requested to the system will be processed through our Change Management process and will receive approval from the Agency prior to implementing any change. Team CNSI's change management strategy includes methods for communicating, evaluating, and approving or rejecting changes that impact the project. We will work with the Agency to participate in a cross organizational change management board to oversee change management on elements that have broader impacts across other modular components of the MPATH environment. All proposed changes will be analyzed to determine system, schedule, scope, cost,

resource, and other impacts so the parties can make an informed decision regarding the need for and timing of the requested change.

Team CNSI's processes have been proven in multiple large engagements including DDI and combined operations and maintenance (O&M) contracts for the states of Washington, Michigan, Illinois, and Utah. We will develop a change management plan for Agency review and approval, at project start-up as a part of the Project Management Plan. Our change management practice applies systematic evaluation, prioritization, coordination, development, approval or disapproval, and implementation of changes after the establishment of a baseline. From start-up and throughout the project lifecycle, changes are managed from their inception to final disposition to ensure that a standard repeatable process is maintained for handling proposed changes and to ensure that unauthorized changes are not introduced into a controlled baseline.

During the DDI phase of the project, changes may be identified by any member or stakeholder of the project. Identification of changes originate from formal and informal reviews of project services and progress, such as schedule reviews, weekly status reviews, or operational observations. To engage the change process, the project manager or designee submits a CR Form in Microsoft SharePoint. Each change request is evaluated by stakeholders as defined in the change management plan including Team CNSI, DPHHS, and other technical or management stakeholders as required by Montana policies and procedures. As a result of the evaluation, the change request is classified for impact (scope, cost and schedule), priority, and risk.

To track the enhancements and defect changes in the O&M phase, Team CNSI utilizes Atlassian Jira. Use of this common change-tracking and project-management software application supports the collaboration between Team CNSI and DPHHS and ensures transparency into the change and software release process. Team CNSI creates a change log to clearly define changes that require solution configuration modifications, such as for enhancement requests. The change log contains a clear definition of the requested change, Team CNSI's response to the change, and an inventory of all impacted system modules and solution artifacts.

SAO13

The Contractor must support the Agency during all audits and reviews conducted by CMS, authorized agencies and contractors, and/or by the State over the life of the contract, to include but not limited to: assisting the Agency and the auditing entity in sample selections, documentation and data gathering, and responding to questions as defined by the Agency.

Team CNSI has extensive experience supporting State agencies through a variety of audits conducted by CMS, State agencies, and contractors. Our implementation and operations teams are experienced at assisting our State customers in meeting with auditors and building documentation and data sets to respond to audit inquiries. Team CNSI has the domain and technical expertise as well as supporting teams who will support the Agency during all audits and reviews conducted by CMS, authorized agencies and contractors, and/or by the State over the life of the contract, to include but not limited to: assisting the Agency and the auditing entity in sample selections, documentation and data gathering, and responding to questions as defined by the Agency.

Team CNSI will assist the Agency with obtaining documentation, pulling data sets, and analyzing provided data sets to support Agency activities for audits (e.g., duplicate, history, bundling, limits, NCCI), program administration, technology design and architecture, hearings, appeals, and fraud, waste, and abuse. Team CNSI will identify staff who will help support these activities as required by the Agency. Additionally, Team CNSI will support the Agency by providing appropriate data (e.g., claims, member, provider) and reports from system as needed.

In order to provide adequate time for thorough and accurate responses to audit requests, Team CNSI requests 10 business days advanced notice of audits. This will allow Team CNSI to properly plan for activities and resources required to successfully complete audits.

SAO14

The Contractor shall provide and maintain a telecommunications link and associated hardware (e.g., VPN, site to site connection) between the claims solution and all associated systems and subsystems.

Team CNSI will provide and maintain a telecommunications link between the claims solution and all associated systems and subsystems. Team CNSI's evoBrix X solution includes a platform that establishes an interoperability layer that supports interactions among components via a variety of protocols. Team CNSI's solution employs several security measures to help ensure the authenticity, integrity, and privacy of data in transit. Our Solution encrypts and authenticates all data in transit at one or more network layers when data moves outside physical boundaries. evoBrix X supports IPSec Transport mode/VPN Tunnel for secured end-to-end (Site to Site) communications, this allows the associated subsystem of claim's solution to connect to the network even when not directly connected to the network. In addition to site to site VPN tunneling, evoBrix X Solution supports both whitelisting and blacklisting which enhances the security and privacy of the entire solution. In the following diagram Figure 3.10.14-4, shows evoBrix X solution connection with associated system through VPN Tunnel.

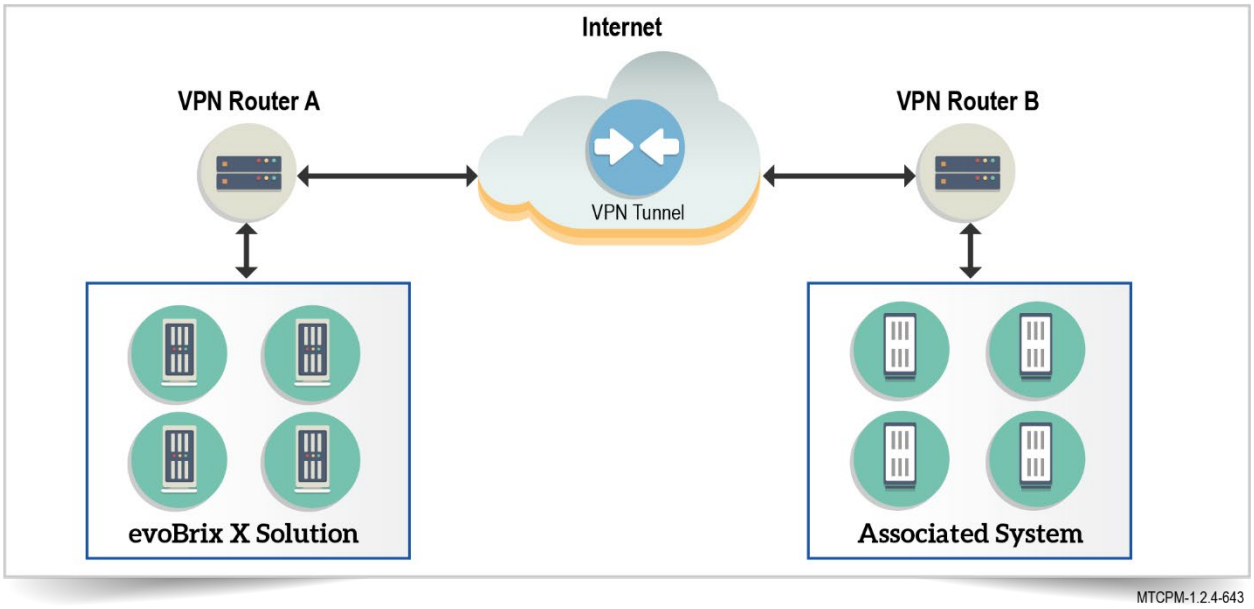


Figure 3.10.14-4. evoBrix X VPN Tunnel. Team CNSI maintains a VPN tunnel to enable secure, reliable linkage between our system and external systems.

SAO15

The Contractor's solution shall proactively monitor claims processing statistics (e.g., denial rates, denial reasons, claim suspense reasons and resolution) and identify and provide necessary training to mitigate continued claim denials as defined the Agency.

Team CNSI's evoBrix X solution proactively monitors all claims as they progress through the workflow including claims that are denied or suspended. The solution is configured to set thresholds that will automatically send alerts if thresholds are reached. For example, the auto deny percentage may be set to 30% or the auto suspend percentage may be set to 2% (in alignment with service levels). Our HealthBeat

tool provides various reporting mechanisms, including dashboards and graphs, that can be used to report on the metrics. The dashboards will be configured to display the metrics based on the Claim processing parameters and generate alerts to notify the appropriate teams when the thresholds are exceeded. Figure 3.10.14-5 and Figure 3.10.14-6 provides sample alerts that are generated when thresholds are exceeded.

Claims processing and payment is a complex set of processes with many factors that may result in denial of claims. Team CNSI collaborate with DPHHS to address continued claim denials that may require training. For example, provide training on proper use of procedure codes, documentation requirements, and submission guidelines.

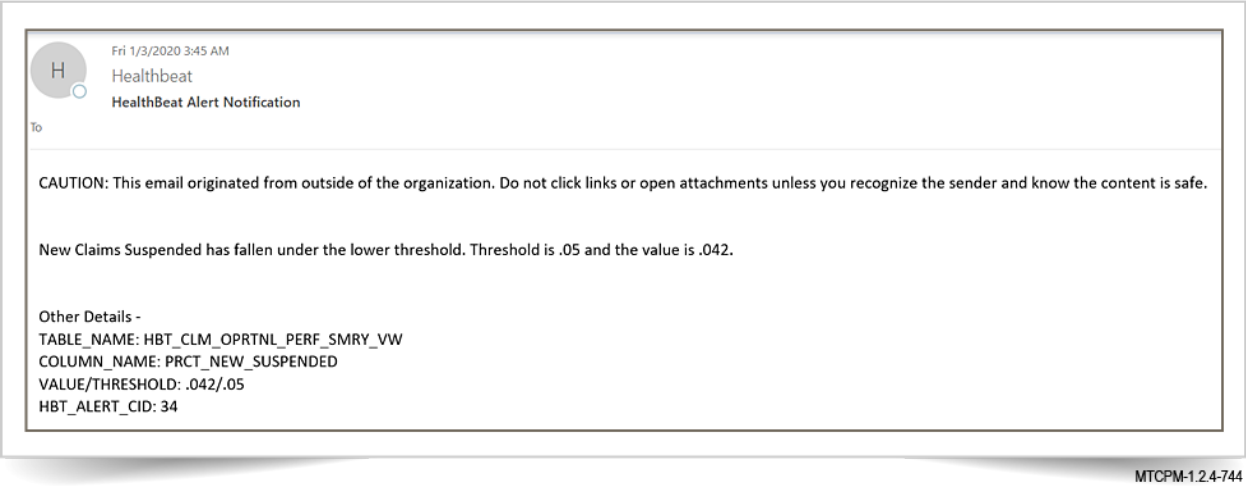


Figure 3.10.14-5. HealthBeat Business Operations Alerts – Claims Suspense Rate Threshold. Sample alert generated by HealthBeat when the claims suspension rate falls below the threshold.

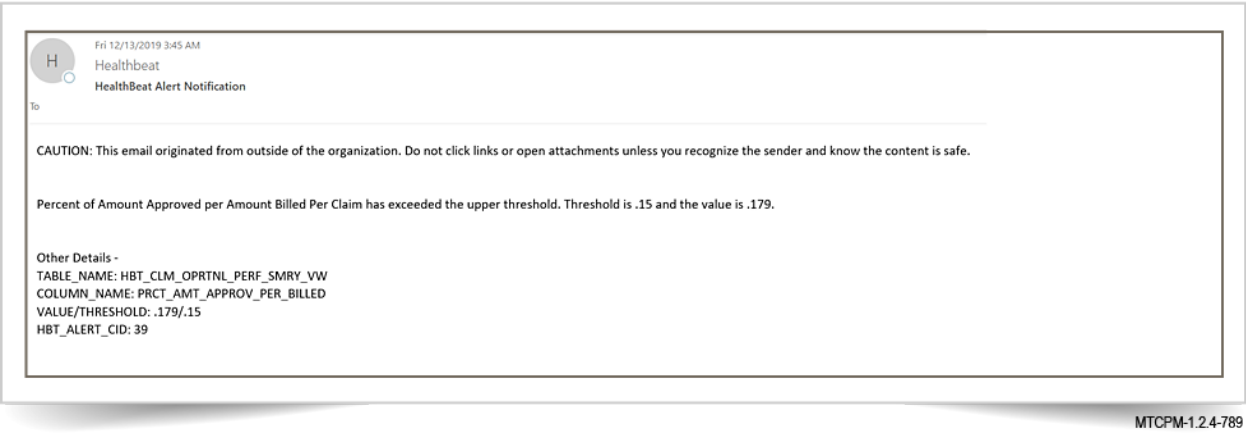


Figure 3.10.14-6. HealthBeat Business Operations Alerts – Approved Amount Threshold Exceeded. Sample alert generated by HealthBeat when the approved amount exceeds the upper threshold.

SAO16

The Contractor's solution shall maintain claims history available for adjustments and inquiry for a duration as defined by the Agency; and all "once in a lifetime" claims.

The evoBrix X Core Claims module will maintain claims history for up to seven (7) years. And in some cases, claims may be retained indefinitely. These are claims flagged as "once in a lifetime" period type as shown in Figure 3.10.14-7 and Figure 3.10.14-8. The system includes pre-configured edits that check the validity of the claims data. The edits include Data Validation (i.e., Reference, Member, Provider), CCI,

Duplicate, Prior Authorization, and Pricing. The dispositions of the edits can be adjusted based on the rules defined by the Agency. The audit trail of all adjustments will be tracked, including who changed the data and when the data was changed. The original and adjusted claims are linked via the Transaction Control Numbers (TCN).

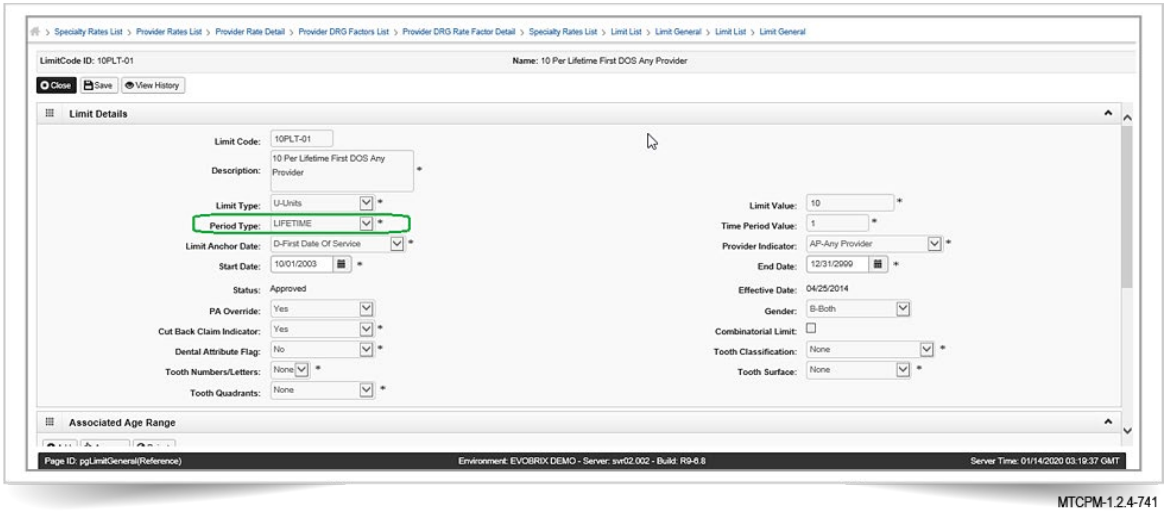


Figure 3.10.14-7. Claims Period Type for Lifetime Claims. Team CNSI's solution provides the capability to retain claims marked with period type of "lifetime".

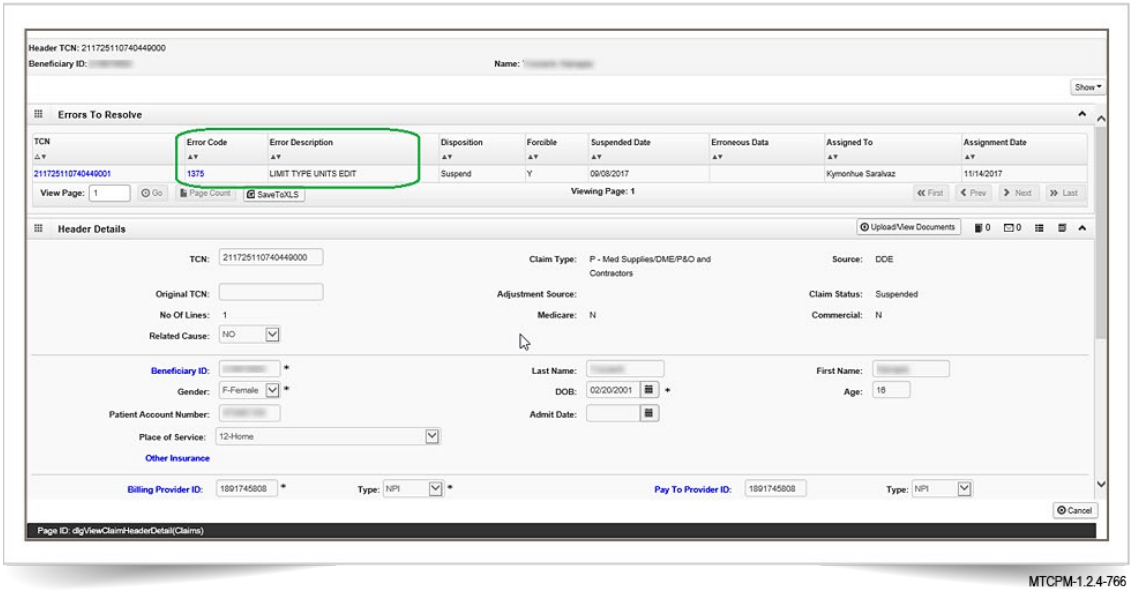


Figure 3.10.14-8. "Once in a lifetime" Claims. Once claims met with 'once in a lifetime' limit criteria then adjudication process will deny the claim.

SAO17

The Contractor's solution shall create, store, and return a unique identification number (e.g., internal control number) for all claims transactions as defined by the Agency.

The evoBrix X Core Claims module provides the ability to providers to send claims through DDE, EDI, Paper or direct file upload. Every claim that is successfully accepted will be assigned a unique Transaction Control Number (TCN), which is used to track and maintain a claim and its attachments in

the system and throughout the adjudication process. The unique TCN is assigned to a Claim and the TCN nomenclature includes the Input Medium Indicator (Paper/Electronic), TCN Category (FFS/Encounters), Batch Date (Year and Julian Date), Adjustment Indicator(Original/Replacement), and the sequence number as shown in Figure 3.10.14-9.

Field	Length	Type	Description
Input Medium Indicator	1	Numeric	0 – Reserved 1 – Paper - Assigned by the Imaging System when the Claim is received in paper format. 2 – Direct Data Entry (DDE) (Web Submission) - Assigned by the System when the Claim is submitted through the DDE Screens 3 – Electronic (HIPAA) - Assigned by the System when the Claim or Encounter is submitted as an electronic batch. 4 – CE System-generated - Assigned by the System when the transaction is generated by the Claims Subsystem. 5 – CM System-generated - Assigned by the System when the transaction is generated by the Contracts Management Subsystem. 6-7 – Reserved 8 – Paper – With Attachments 9 – Reserved
TCN Category	1	Numeric	0 – Reserved 1 – FFS - Assigned to any claim that is submitted directly to the System including Institutional, Professional and Dental Claims. 2 – Crossover – Assigned to any Claim received from GHI – the national Medicare intermediary. 3 – Encounters - Assigned by the loading routine when the indicator on the X12 Claim is set as an Encounter including Institutional, Professional and Dental. 4 – Capitation Claims – System-generated claims created by the Contracts Management Subsystem. 5 – Gross Adjustments – System-generated by Claims and Contracts Management Subsystems. 6 – Pharmacy Encounters – Stored and assigned TCN in the Data Warehouse. Not available in CHAMPS. 7 – Recurring Payments – System-generated by Claims and Contracts Management Subsystems. 8-9 – Reserved
Batch Date	5	Numeric	YYDDD – Year + 3-digit Julian date.
Adjustment Indicator	1	Numeric	1 – Original Claim 7 – Replacement Claim 8 – Void All valid NUBC frequency type codes are mapped to one of these values for internal processing (Patrick – add appendix for mapping).
Sequence Number	7	Numeric	By input medium, starting with 0000001 at the beginning of each Julian date.
Line Number	3	Numeric	Line Number will begin with 001 for every new Claim. The header will have the line number as 000.

Figure 3.10.14-9. TCN Composition. A unique TCN is assigned to claims to provide tracking and linking capabilities on a consistent basis.

SAO18

The Contractor's solution shall have the ability to create, maintain, and produce regularly-scheduled and ad-hoc publications (both print and electronic) of multilingual documents as defined by the Agency.

Team CNSI has the capability to create, maintain, and produce multilingual documents on a regular or ad-hoc basis as directed by the Agency in a variety of formats (print and electronic). We provide multilingual options for portal pages, IVR messaging, published notices, and documentation in English and Spanish as a standard feature. We can also support additional language upon requests. Team CNSI will work with DPHHS during the Design phase to clearly define and document the likely languages that may need to be supported.

SAO19

The Contractor shall provide translator and integrated mapping software (e.g., flexible mapping functionality supporting all required formats and transactions, allowing for structure and information to be extracted directly from database tables, providing the ability to receive, assemble, validate, encrypt, respond, and transport batches of data to and from covered entities and other trading partners; accept, code, decode, balance, and transmit all current and future HIPAA healthcare transactions (e.g., 837, 835, 270, 271, 276, 277 (including unsolicited), 278, 820, 834, 997,999, 991, 824, TA-1) and providing support for automatically re-submitting the transaction when a transmission error occurs) as defined by the Agency.

The evoBrix X Integration Gateway includes the Edifecs validator and translator to provide translation services. Edifecs includes an integrated mapping software. The system seamlessly translates information, as needed, for interfaces with minimal configuration. Our approach and use of Edifecs accounts for all data elements currently in use and is flexible to accommodate other data elements that may be needed to align with DPHSS business processes for interaction with external entities. The evoBrix X Integration Gateway provides EDI Services that have a proven track record of processing HIPAA 5010 transactions for over decade in the states of Michigan and Washington. Team CNSI's solution includes current federal mandated 5010 transaction sets. Our solution includes the following X12 transactions (837 P/D/I, 278 I/O, 270, 271, 276, 27,2777 U, 835, 834, 820, 824, 997, 999 and TA1) with up to 5 situational elements per transaction to support state specific requirements and NCPDP D.0 and NCPDP Post Adjudication transactions. Any additional non-mandated transactions or future mandates with state specific X12 requirements will be addressed through a change request. Figure 3.10.14-10 depicts the flow of both inbound and outbound HIPAA transactions.

The following provides a summary of our EDI capabilities by processing phase.

Validation. Inbound and outbound files will be validated against SNIP guidelines during validation and a report will be generated with appropriate acknowledgments. As part of the validation process inbound files are split at the transaction level into good and bad transactions. This process will be updated to split the files at the claim level to split the transaction into good and bad claims.Standard TA1,d 99, 997 and 824 acknowledgementst will be sent to the submitter for each claim at group level. The acknowledgement for bad claims will detail the reason for failure for these claims to help the submitter resubmit claims. Good claims proceed to the next step in the intake process. Validation is accomplished by using Edifecs XEngine.Translation. The translation stage is where inbound transactions are translated from HIPAA to evoBrix X format and outbound transactions are transformed from evoBrix X to HIPAA format. The evoBrix X format is called an Internal Record Layout (IRL). This decoupled architecture enables evoBrix X to support multiple X12 formats without affecting the underlying business process. Translation is accomplished with Edifecs XEngine (MapBuilder).



database. While loading these files, the data is subjected to loading business rules tailored to meet DPHHS requirements. All the information from the HIPAA transactions are loaded into the system per HIPAA/HITECH mandates and state-specific companion guide rules. The evoBrix X CPMS solution's loading process is a centralized component that handles loading all claims submitted in X12, direct data entry (DDE), and paper format.

- Outbound File Generation. The outbound transaction IRL files (i.e., HIPAA 271, 277, 27 ,277U, 834, 8208 and 835) are generated as required by HIPAA/HITECH and state-specific companion guide rules. The evoBrix X CPMS solution is configurable and can modify the schedules of these transactions to meet the SLAs specified by DPHHS. Some of the transactions (i.e., HIPAA 271, 277 and 278) can have 24x7 schedules, while others can have fixed or event-based schedules, such as once a pay cycle, monthly, weekly, or daily. After this stage, outbound IRL files go through the translation and validation stage before pushing the files to trading partners.
- Recovery Process. This stage is to recover all inbound and outbound transactions in validation, translation, loading, and outbound file generation processes. This is a very use full process where the system automatically reset all failed transactions to process again and recover it automatically in various stages. This capability helps reduce operations workload when the solution is in production. This stage is to recover all inbound and outbound transactions in validation, translation, loading, and outbound file generation processes. This is a very use full process where the system automatically reset all failed transactions to process again and recover it automatically in various stages. This capability helps reduce operations workload when the solution is in production.

SAO20

The Contractor's solution shall provide predictive modeling capability for the management of quality and cost-effectiveness of healthcare services, as defined by the Agency.

With a demonstrated history of 20 years in architecting, implementing, and operationalizing enterprise healthcare claims adjudication solutions for a multitude of state and Federal government clients, Team CNSI has gained insight into patterns associated with medical claims billings and the types of medical services that has a direct correlation to the quality and cost-effectiveness of healthcare. As a result of this rich experience in processing more than 100 million claims every year for our customers, Team CNSI recognizes the challenges - particularly the quality and financial impacts - posed by improper billing associated with claims and potential duplicative and medically unnecessary services that has a significant bearing on both quality and cost. Team CNSI will provide predictive modeling capabilities and support through business operations that leverage probabilistic techniques to identify patterns of improper billing and services associated with claims submitted by providers. Figure 3.10.14-11 summarizes Team CNSI's value proposition for facilitating successful business operations in conjunction with the associated data-driven decision making through predictive-modeling capabilities that are needed to quantitatively manage the State's priorities for reigning in quality and cost of healthcare services.

Team CNSI's Business Operations Value Proposition	Data-driven Decision-Making via Predictive Modeling Capabilities
■ Deep subject matter expertise with Healthcare Policy and Operations ■ Extensive experience with Medicaid and Medicare data in multiple States and at the Federal level ■ Ability to leverage existing data marts already built for evoBrix X Core Claims module ■ Ability to ingest data from a variety of external sources to help support the State's holistic priorities for effective management of quality and cost ■ Integration and Data Science services that complement the evoBrix X Reporting module and operational data	■ Performing descriptive and exploratory raw data analysis for efficient decision making ■ Evaluating and validating the predictive model training output to ensure model optimization and accuracy ■ Periodically analyzing and investigating changes in granular/aggregate data patterns or trends to recommend optimal model versions, techniques, and configurations aligning with the constantly shifting provider billing patterns and healthcare service delivery to the Medicaid beneficiaries ■ Leveraging the evoBrix X Reporting module and HealthBeat dashboards for engaging user visualizations to enable transparency and facilitate dialogue with the State for ongoing management of quality and cost

Figure 3.10.14-11. Team CNSI's Value Proposition Predictive Modeling. Team CNSI has gained insight into patterns associated with medical claims billings and the types of medical services that has a direct correlation to the quality and cost-effectiveness of healthcare.

SAO21

The Contractor shall develop and maintain a configurable summary dashboard for ticket requests with the ability to drill-down to detailed information to include, but not limited to: ticket type, identifier, prioritization, description, related notes or comments, request date, requester, start date, assigned resource(s), estimated completion date, estimated hours, hours worked to date, documentation impact and status, testing reports and status, agency approval, implementation date, post implementation updates as defined by the Agency.

The evoBrix X platform also includes our flagship monitoring solution, HealthBeat, which provides multiple dashboard views, business and system metrics, and an SLA performance monitoring dashboard. HealthBeat®, illustrated in Figure 3.10.14-12. provides operational transparency and real-time data to stakeholders for validating operational performance and meeting program needs. HealthBeat is integrated

with our Jira Service Desk and will provided detailed and configurable dashboard data on service performance.



Figure 3.10.14-12. HealthBeat® Business Operations Dashboard. Team CNSI's HealthBeat® provides the State with near real-time metrics and full transparency into the program.

HealthBeat® offers the ability to monitor, track, and report on operational data to support business activity stewards to improve quality of delivery and streamline operations. Team CNSI intends to leverage HealthBeat® to provide transparency of performance to stakeholders in the form of:

- Real-time visibility into business operations (align to MITA business areas) for program effectiveness and operational performance
- SLA management and measurement reporting
- Interactive scorecards, dashboards, and drill-down functionality
- Configurable metric thresholds with events-based alerting

SAO22

The Contractor's solution shall serve as the EDI broker/gateway to create, edit, receive, and respond (e.g., real-time, SFTP, batch file upload), translate, and process X12, standardized transactions and current and future HIPAA standard transactions as defined the Agency.

The evoBrix X Core Claims module provides an EDI framework that has the capability to process HIPAA X12 transactions through various modes of submission in both real time and batch. The solution provides the capability for the providers to directly upload the HIPAA files using the portal, as shown in Figure 3.10.14-13, or place files on a file server (SFTP). The evoBrix X solution accepts claims in X12 format and pharmacy claims in NCPDP D.0 and post adjudicated NCPDP format. Any non-standard format conversion to X12 standards will be offered to the State through a change request. Our evoBrix X EDI module accepts HIPAA transactions using the proprietary EDI Gateway, Council for Affordable Quality Healthcare (CAQH) CORE Phase III compliant API Gateway and using the EDI File Upload feature from evoBrix X screens from established trading partners. The EDI engine then validates and translates the files for further processing. Team CNSI has experience integrating evoBrix X EDI framework with state-

specific gateways as well as implementing a new EDI gateway. The EDI framework also has the capability to generate 999 and TA1 EDI acknowledgement transactions as response to the EDI files received from the Providers.

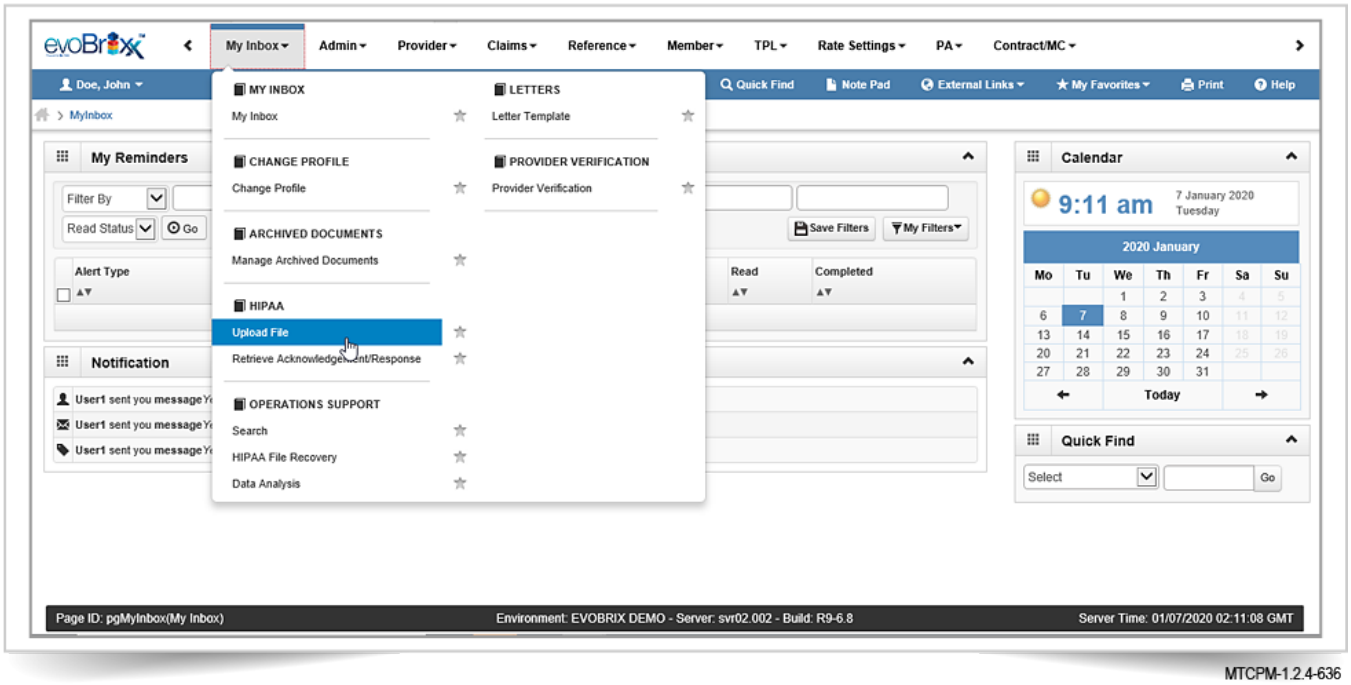


Figure 3.10.14-13. Upload HIPAA Files. Team CNSI's evoBrix X EDI module accepts HIPAA transactions using the HIPAA File Upload feature.

SAO23

The Contractor shall provide a secure web portal with the ability for members to receive REOMB and respond, as defined by the Agency.

Team CNSI's evoBrix X Core Claims module will be customized to generate electronic Recipient Explanation of Medical Benefits (REOMB) notices based on the Agency's business policies and will be delivered via an easy-to understand format on the member portal, myHealthPortal. Team CNSI's evoBrix X CPMS solution provides a user-friendly member myHealthPortal that allows Medicaid members to securely access their health information. The myHealthPortal enables members to request REOMBs, in which a member will selects a specific service or a list of services to be included in the REOMB.

SAO24

The Contractor shall receive, track, monitor, and respond (e.g., using Agency approved template, free-form) to inquiries through a secure portal inbox, as defined by the Agency.

evoBrix X CPMS solution provides the capability to do secure chat and inquiries with Option B, Call Center functionality. Team CNSI will integrate MedChat, a live chat software with a Web portal, into the SYSTEM to implement the interactive online support feature. Once a provider or member logs into the secured portal, a chat icon will be available on the home page of the Provider or Member portal. When the user clicks on the chat icon, a window will open to interact with a CCSR. An available CCSR will be notified of chat request. After the interaction is complete, either the user or CCSR can end the session. The entire chat session history will be maintained in the database with provider and State staff details for future reference. Chat history will be tracked in CRM as service requests.

SAO25

The Contractor's secure web portal shall allow external users inquiry of member information (e.g., eligibility, demographic, detailed description of covered benefits and utilization information, service authorization requirements, copayment and out-of-pocket accumulation) as defined by the Agency.

The evoBrix X CPMS solution provides a user-friendly member myHealthPortal that allows Medicaid members to securely access their health information, as shown in Figure 3.10.14-14. The myHealthPortal enables members to check eligibility related to covered benefit plans and specific services for which the member is eligible. The evoBrix X CPMS solution provides a user-friendly member myHealthPortal that allows Medicaid members to securely access their health information, as shown in Figure 3.10.14-14. The myHealthPortal enables members to check eligibility related to covered benefit plans and specific services for which the member is eligible.

The evoBrix X CPMS solution maintains all the member information received from the external agency systems. All the data is validated based on the business rules provided by the State and stored in the evoBrix X database. Member inquiry is one of the important business functions. The evoBrix X solution provides online screens for Providers to view consolidated member information such as demographics, address, benefit plans, type of service, associated program, and eligible dates. The solution allows the Providers to enter the input parameters as shown in Figure 3.10.14-15 to retrieve the member details. In addition, the evoBrix X CPMS solution exposes an API which supports member inquiry to requests from authorized external systems.

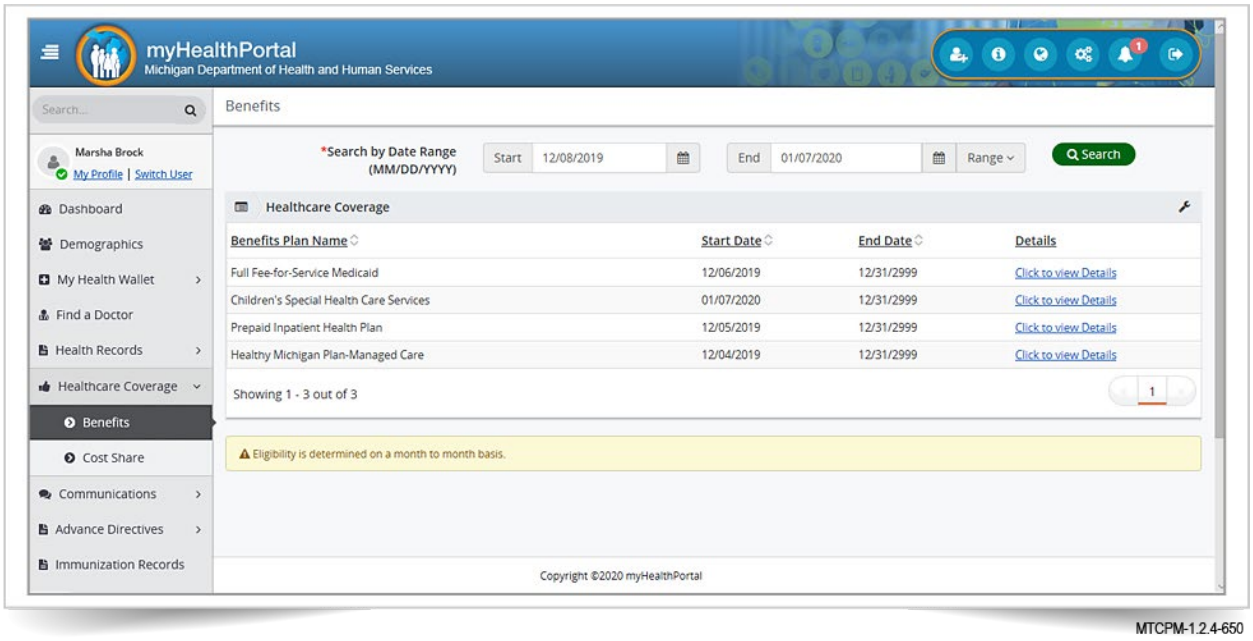
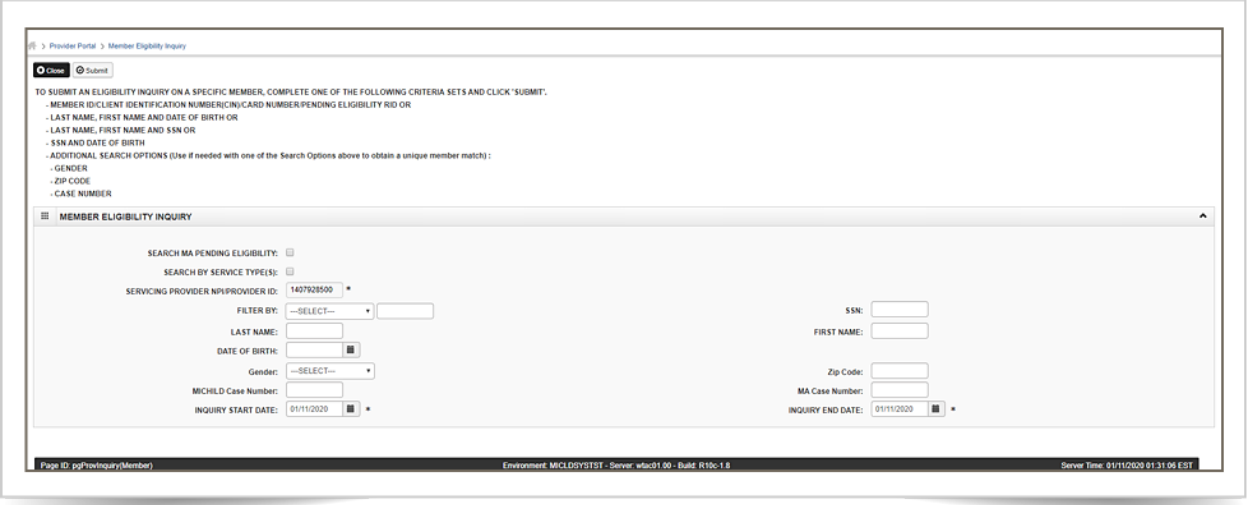


Figure 3.10.14-14. myHealthPortal Benefits Plan Sample Screen. myHealthPortal provides Medicaid members access to a wide range of information related to their healthcare and coverage through a web portal.



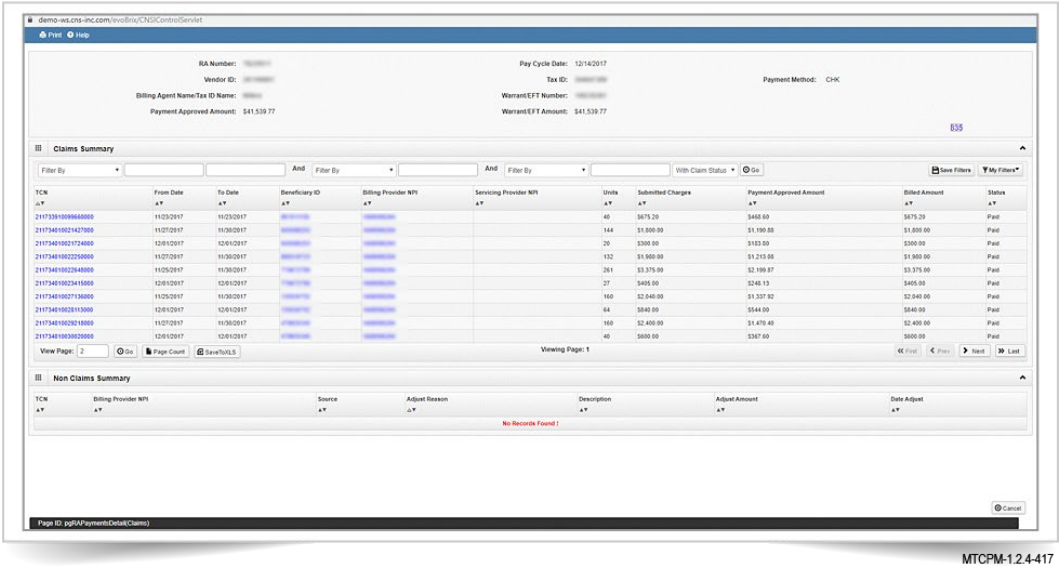
MTCPM-1.2.4-792

Figure 3.10.14-15. Member Eligibility Sample Screen. The screen allows the Providers to enquire member benefits and demographics.

SAO26

The Contractor shall provide a secure web portal with the ability to view, retrieve, download and print remittance advice (e.g., x12 835, PDF) as defined by the Agency.

The evoBrix X CPMS solution provides the ability for authorized providers to retrieve their weekly X12 835s and paper RAs. After processing the payments, all the claims will be updated with appropriate check or EFT information received from the treasury system. The evoBrix X EDI module generates the X12 835 by pulling all the paid and denied claims processed during the pay cycle. Once this is complete, the evoBrix X Correspondence Module generates the paper remittance advice (RA) in PDF format, it is stored it in the ECM and transmitted to central printing for provider mailing. The RA documents are archived and made available to providers through the provider portal and to agency staff through the evoBrix X Core Claims screens as shown in Figure 3.10.14-16.



MTCPM-1.2.4-417

Figure 3.10.14-16. Provider Payment Remittance Advice Details. The screen allows the Providers to enquire member benefits and demographics.

SAO27

The Contractor provide a web portal with the capability to receive, store, maintain (e.g., version history) and upload documents, as defined by the Agency.

evoBrix Core Claims module allows the Provider to upload any claim supporting documents. The supporting documents can be uploaded as part of claim submission process or if the claim has already been submitted then the Provider can open the claim and upload the attachment. evoBrix Core Claims module offers authorized users an easy-to-use interface to conduct secure retrieval of their electronically submitted documents. The module seamlessly integrates with the evoBrix X ECM module which provides document management features and technology frameworks that meet the requirements. ECM will be the single repository for all system documents and provider support materials. Providers can upload documentation in support of their claims, such as a copy of the PA, Patient Pay and any certifications etc. State staff can also upload documentation on behalf of the providers. When the user(s) invoke(s) the upload functionality, the evoBrix X CPMS solution internally calls the ECM API to archive the uploaded document within the ECM and index the document based on pre-configured indexed parameters, to aid in document retrieval later. Any uploaded documents can later be viewed through the self-service portal. It also provides a rich filter capability to allow the user to find specific documents based on criteria. The self-service portal's Document Archive List is shown in Figure 3.10.14-17.

Any uploaded documents can later be viewed through the self-service portal. It also provides a rich filter capability to allow the user to find specific documents based on criteria. The self-service portal's Document Archive List is shown in Figure 3.10.14-17.

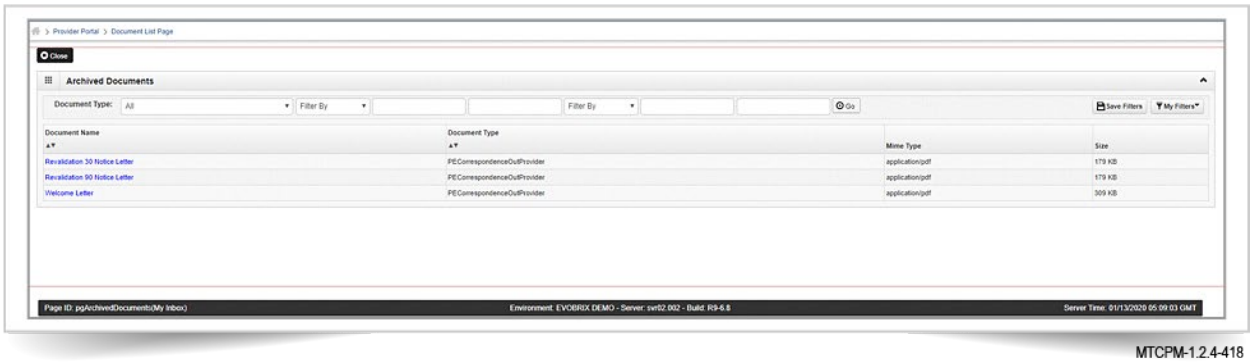


Figure 3.10.14-17. Archived Document Lists. The screen allows the Providers to enquire member benefits and demographics.

SAO28

The Contractor's solution shall provide a web portal with the ability for a secondary navigation scheme (e.g., breadcrumb trail) for navigation on the web portal as defined by the Agency.

evoBrix Core Claims module offers a powerful user interface that is designed to work on most commonly used browsers. Team CNSI's CPMS solution can be accessed by human-readable URLs. Once a user initially logs into the system, all navigation is performed through evoBrix X Core Claims module menus. The functions available through the menu system are controlled by Roles Based Access Control (RBAC). Users can select frequently accessed pages as their favorites to directly visit the pages once logged into the system. To help users visit the pages they visited earlier with the preserved context, Team CNSI's CPMS solution displays a breadcrumb trail, as shown in Figure 3.10.14-18. The user can click any link on the breadcrumb trail to quickly access the page they visited earlier in the session. This works better than

the forward and backward buttons provided in standard browsers because it ensures that session integrity is maintained. Team CNSI's CPMS solution also provides separate portals for Member and Provider.

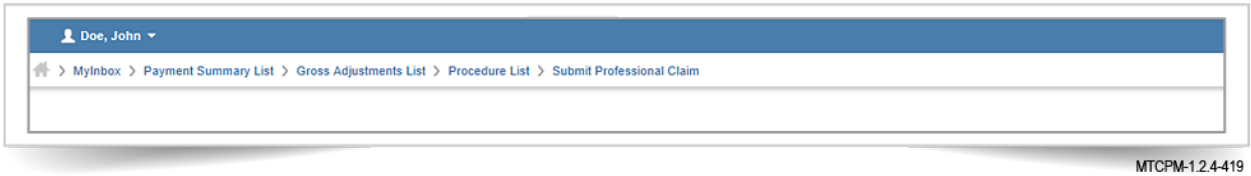


Figure 3.10.14-18. Navigation Breadcrumbs. The evoBrix X solution provides a powerful user interface that focuses on providing a positive user experience.

SAO29

The Contractor's solution shall provide operational support and maintenance of the web portal to include a dashboard detailing usage statistics (e.g., user count, transactions, uploads, downloads, secure messages) as defined by the Agency.

The evoBrix X platform also includes our flagship monitoring solution, HealthBeat, which provides multiple dashboard views, business and system metrics, and an SLA performance monitoring dashboard. HealthBeat, shown in Figure 3.10.14-19, provides operational transparency and real-time data to stakeholders for validating operational performance and meeting program needs.



Figure 3.10.14-19. HealthBeat Business Operations Dashboard. Team CNSI's HealthBeat provides the State with near real-time metrics and full transparency into the program.

HealthBeat offers the ability to monitor, track, and report on operational data to support business activity stewards to improve quality of delivery and streamline operations. Team CNSI intends to leverage HealthBeat to provide transparency of performance to stakeholders in the form of:

- Real-time visibility into business operations (align to MITA business areas) for program effectiveness and operational performance
- SLA management and measurement reporting
- Interactive scorecards, dashboards, and drill-down functionality
- Configurable metric thresholds with events-based alerting

SAO30

The Contractor's solution shall provide a web portal with comprehensive functionality (e.g., contacting the Agency or a payee, view summary and detail information, remittance advices, warrant summaries, complete and submit an EDI trading partner application, frequently asked questions) as defined by the Agency.

The evoBrix X CPMS solution provides a summary and detailed information of remittance advices and warrant information to the authorized users. evoBrix X CPMS solution provides list and detail pages to view the payment and remittance advice details as shown in Figure 3.10.14-20 and Figure 3.10.14-21, respectively. Every page within the application comes with help pages associated to it where user can find the usage details of the page. All the frequently asked questions and cover sheets will be available to the providers under external links so that they can be accessible within in the evoBrix X CPMS solution, as shown in Figure 3.10.14-22.

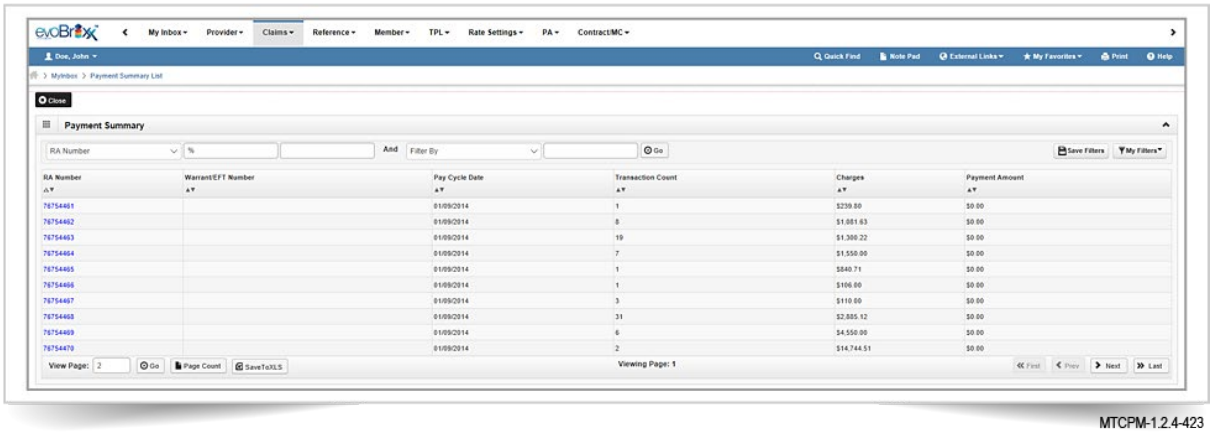


Figure 3.10.14-20. Provider Payment Remittance Advice List. Our solution provides list and detail pages to view the payment and remittance

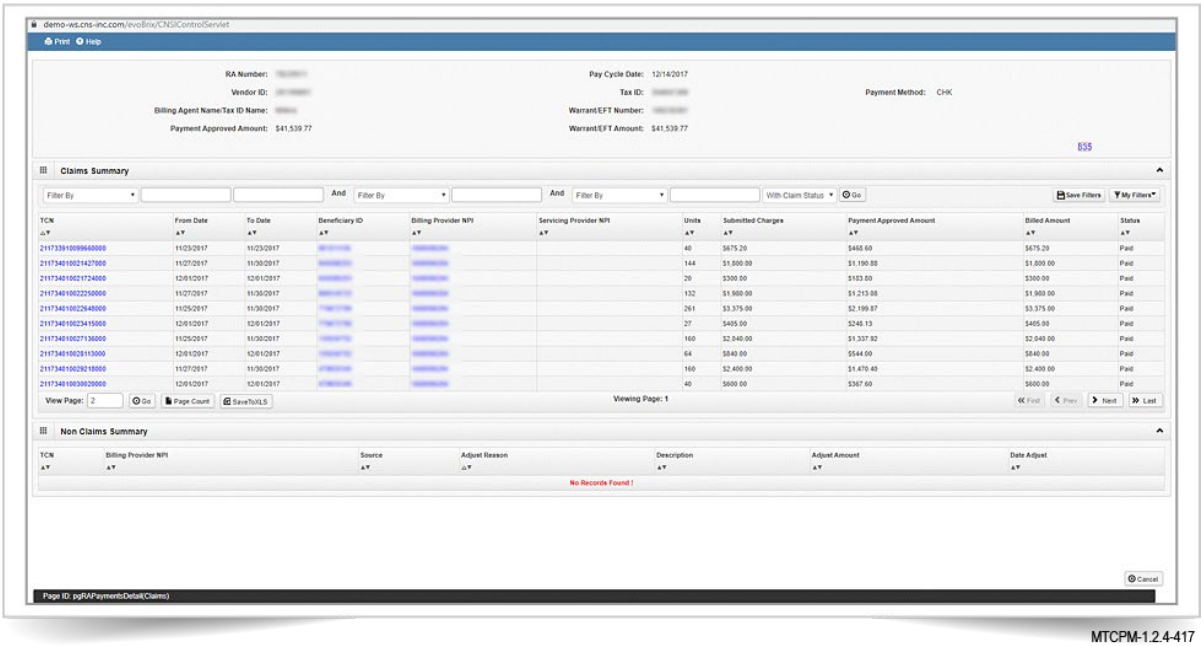


Figure 3.10.14-21. Provider Payment Remittance Advice Details. Our solution provides list and detail pages to view the payment and remittance advice detail.

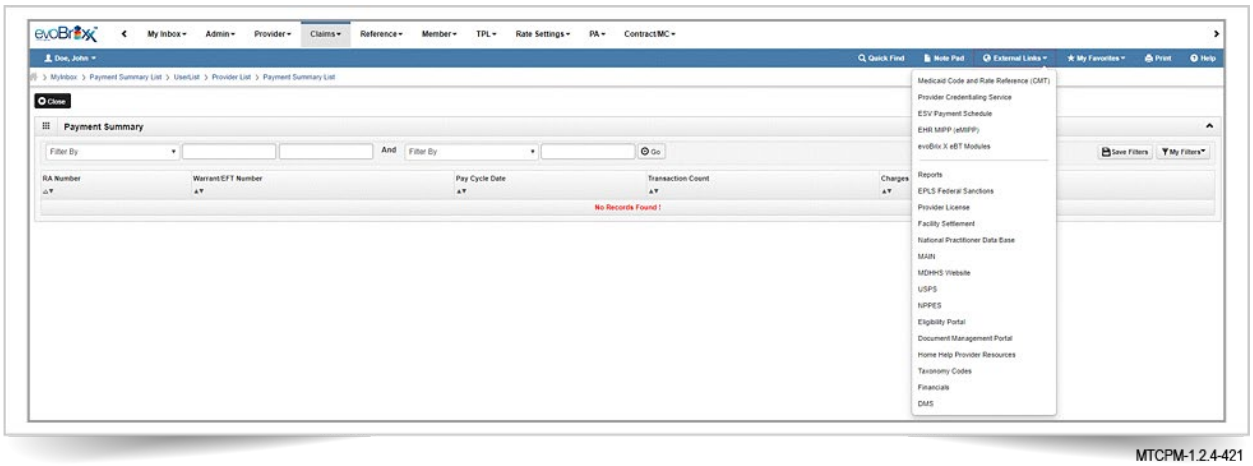


Figure 3.10.14-22. External links and Help. Providers have access to external links and help pages.

SAO31

The Contractor's solution shall manage and maintain EDI transaction sets and permissions (e.g., eligibility inquiry and response only, 837 Dental submission and response only) for covered entities and/or trading partners as defined by the Agency.

The evoBrix X CPMS solution will have interfaces to receive the provider details from the external Provider module provided by another vendor. As part of data exchange, the evoBrix X CPMS solution will receive and store providers, clearing houses, and billing agents who have established trading partner relationships with DPHHS. The system will validate the enrollment information and identify trading partners who submit EDI transactions for them and maintain their EDI transaction sets permissions. The evoBrix X CMPS solution allows providers to submit EDI transactions based on trading partner relationship between provider and DPHHS.

As part of the implementation phase, Team CNSI will establish a test region for testing and certifying EDI transmissions. All entities submitting X12 ASC compliant EDI transactions are required to submit test EDI transactions and receive the appropriate response from test region before they will be certified by Team CNSI to submit X12 ASC compliant EDI transactions to evoBrix X Core Claims module. When changes to X12 standards occur, each entity submitting EDI transactions to evoBrix X Core Claims module must repeat the certification process before submission of transaction compliant with the revised standards to the production environment will be permitted. The evoBrix X Core Claims module uses this certification process to ensure that entities are submitting X12 compliant transactions to production and avoid potential issues that might be caused by the submission of non-standard compliant transactions into production. evoBrix X Core Claims module uses this certification process to ensure that entities are submitting X12 compliant transactions to production and avoid potential issues that might be caused by the submission of non-standard compliant transactions into production.

evoBrix X Core Claims module uses this certification process to ensure that entities are submitting X12 compliant transactions to production and avoid potential issues that might be caused by the submission of non-standard compliant transactions into production.

SAO32

The Contractor shall create, maintain (e.g., current and historical versions) Agency-specific EDI companion guides in a format and timeframe defined by the Agency. All EDI companion guides must have the required Agency and/or federal approval.

Team CNSI has extensive experience in implementing X12 version 5010 and interacting with providers, clearing houses, and third-party vendors using the following HIPAA transactions as required by 45 CFR Parts 160 and 162:

- 276 – Electronic Claim Submission System Request
- 277 – Electronic Claim Submission System Response
- 835 – Healthcare Claim Payment Advice
- 837D – Healthcare Claim – Dental
- 837I – Healthcare Claim – Institutional
- 837P – Healthcare Claim – Professional
- 999 – Functional Acknowledgment
- TA1 – Interchange Acknowledgment
- 278 – Prior Authorization Request
- 278 – Prior Authorization Response
- 834 – Benefit enrollment and maintenance
- 820 – Premium Payments

We also acknowledge responsibility for making necessary changes to the HIPAA companion guides that are in place today. Figure 3.10.14-23 describes EDI X12 HIPAA transactions and their interacting components within the evoBrix X Core Claims module.

[redacted]

SAO33

The Contractor shall provide a web portal with the ability to post and archive user specific or non-specific announcements or alerts (e.g., member, provider, specific benefit plan, and user role) that are displayed at user sign-on or at a frequency defined by the Agency. Users should be required to acknowledge the announcement so that it is not repeatedly displayed at subsequent sign-on, as defined by the Agency.

The evoBrix X CPMS solution enables users to receive alerts and emails based on the configuration. Whenever authorized users sign in, their inbox is displayed as shown in Figure 3.10.14-24. The inbox has announcements, alerts, and other reminders. The alert and notifications are delivered to the users via a secured message to their inbox within evoBrix X. It enables e-mail and inbox notification to be associated to an event and workflow. The alert type, along with the alert due data reminds users which work items require their attention. Users can read, responds, forward and delete messages from My Inbox, once deleted they won't be shown to the user anymore in subsequent logins. These are shown to the users based on the user security profiles set up in the system.

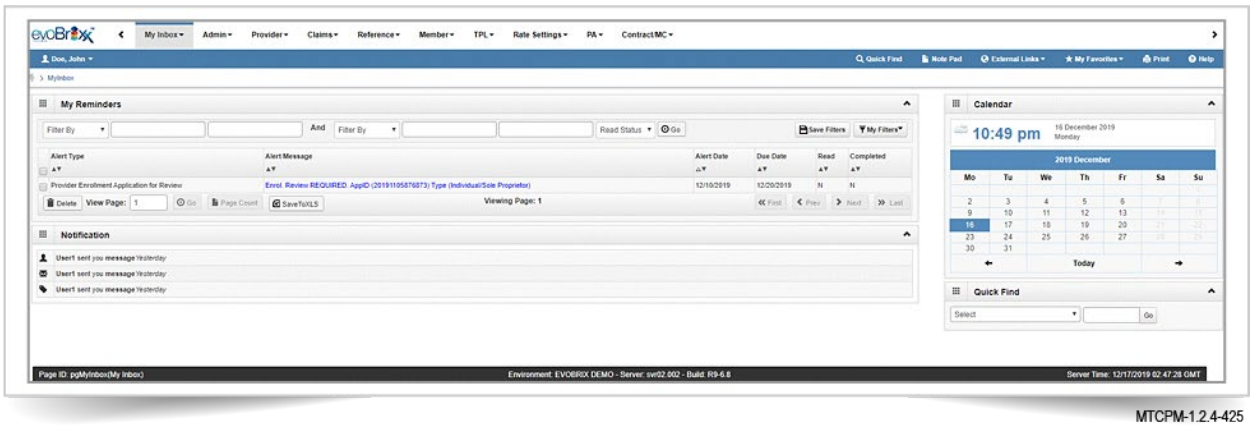


Figure 3.10.14-24. User Inbox. The inbox provides a central area for a user to receive announcements, alerts, and other reminders.

SAO34

The Contractor shall provide an interactive web portal with smart links to Agency, Federal, provider, and member resources and information (e.g., provider manuals, instructions, bulletins, program descriptions and updates, fee schedules, eligibility criteria, forms, member guides, certifying agencies, SSA, public health care and nutritional programs) for viewing, downloading, and printing as defined by the Agency.

The evoBrix X CPMS solution provides an interactive web portal that allows users to configure external links that will store the links to the external applications that users will need to access from the application, as shown in Figure 3.10.14-25. All the required materials like provider manuals, instructions, bulletins, program descriptions and updates, fee schedules, eligibility criteria, forms, member guides, certifying agencies, SSA, and public health care and nutritional programs can be configured to provide access to the content. These external links are security driven and shown to the user based on the security profile using witch user logged into the system.

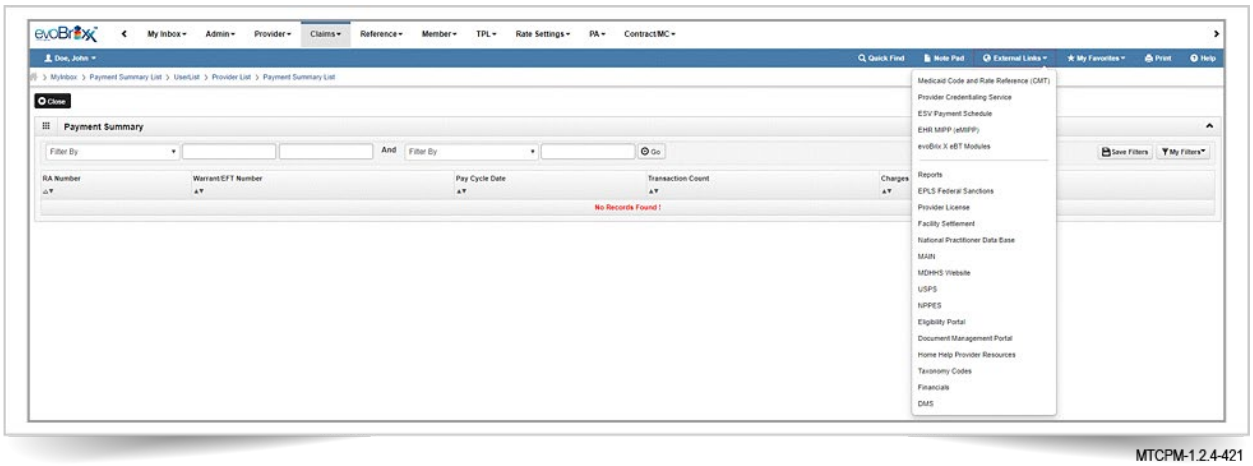


Figure 3.10.14-25. External links and Help. Providers have access to external links and help pages.

SAO35

The Contractor shall establish and maintain a reconciliation process for all paper claims and attachments received and provide a dashboard with daily aggregate summary and the ability to drill down by specific billing provider, claim type (e.g., professional, institutional, dental, nursing home) and search capabilities using all available data elements to validate all claims and attachments received are processed according to Agency defined business rules.

The evoBrix X CPMS solution also includes our monitoring solution, HealthBeat, which provides multiple dashboard views, business and system metrics, and an SLA performance monitoring dashboard. The metrics on this dashboard can be configured to display the statistics of the paper claims and the attachments received on a daily basis. The graphs can be configured to show the data either through aggregation or by the claim type or other parameters. The solution also generates daily reports to provide an overview of the total paper claims received and their current disposition.

In addition, the evoBrix X CPMS solution provides an interactive web portal that allows the Provider to logon to the application and select claims by billing provider, member, and claim type. The user can further drill down to find more claim details on any particular claim. The System also provides various search capabilities to locate any particular claim as shown in Figure 3.10.14-26 and Figure 3.10.14-27.

Team CNSI's evoBrix X CPMS solution has the capability to accept attachments, including hard copy documents. Whether submitted electronically or as scanned paper documentation, attachments are matched to claims and identified by the TCN. The attachments are then loaded into the ECM (i.e., FileNet) for searching, viewing, or retrieving during the claims adjudication process. The evoBrix X CPMS solution provides intuitive search criteria and permits searches based on file name, TCN, document type, provider details, and other related data.

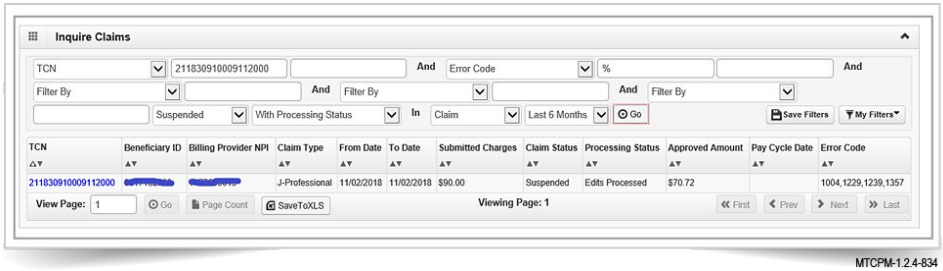


Figure 3.10.14-26. evoBrix X Core Claims Module Inquiry Screen. The Core Claims module offers a user-friendly interface to search on specific claims information.

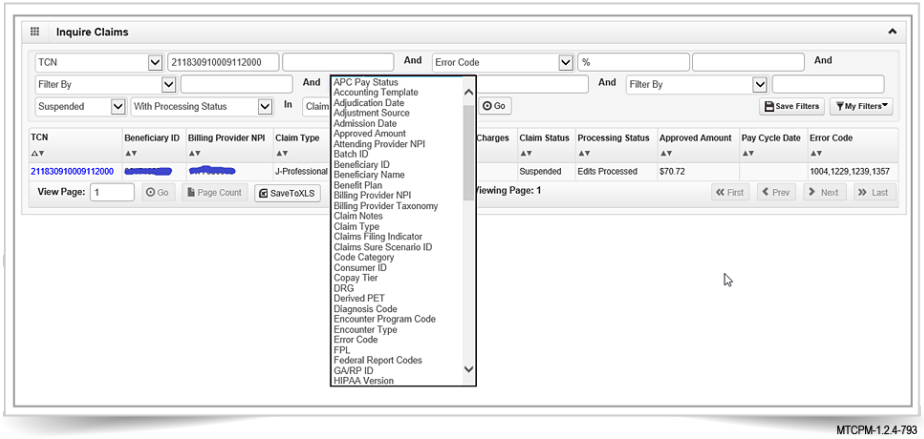


Figure 3.10.14-27. Inquiry Screen's Dropdown Menus. The dropdown menus offer providers an easy way to enter a TCN and filter criteria to view a claim's current status, processing status, approved amount, and edit error codes for which a particular TCN is either paid, denied, or suspended.

SAO36

The Contractor shall identify, procure, and maintain licenses for all reference data (e.g., payment methodologies, claims editing, translator(s)) and electronic copies (e.g., implementation guides, reimbursement methodologies, National Correct Coding Initiative policy manual) necessary to support the acceptance, editing, pricing, adjudication, and payment of healthcare and non-healthcare claims for use by all modules as defined by the Agency. These licenses must allow the reference data to be shared with other modules (e.g., care management, EDW, provider services, TPL, customer care, fraud waste and abuse) to support the administration of the Agency healthcare programs.

Team CNSI's evoBrix X CPMS solution ensures that all reference codes are pre-loaded into the evoBrix X Benefits and Reference Data Management area and checked against the National Standard code sets. The historical information for each code set is maintained with an effective date and end-date. Some of the major reference codes in the system include CPT-4 procedure codes, Modifiers, ICD-10 diagnosis (ICD-10-CM) and procedure (ICD-10-PCS) codes, DRG codes, APC codes, Revenue Codes, HCPCS codes, Revenue Code/HCPCS relationships, Resource Based Relative Value Scale (RBRVS), OPPS-based rates; NDC codes. System will be customized to accept BETOS and MDC code sets.

Our solution accepts feeds from CMS and other approved sources on code sets, custom loads and variable rates to support the contractual agreements between the Agency and its partners. Code sets can be updated using one of two methods:

- The solution's UI screens in the Benefits and Administration area; or
- Background services.

Team CNSI will make changes to reference code sets, with appropriate testing and validation, only upon receiving authorization from the Agency or upon mandates from CMS. Our solution also supports reference data ingestion from multiple channels and tracks reference information changes related to payment methodology. Based on the agreed-upon methods and schedules in the DDI phase, Team CNSI will set up our solution to update the reference data periodically.

Supported Code Sets. As part of the claims adjudication process, our solution validates all codes that are received on a claim. These codes are checked against the national standard code sets that are preloaded into the Benefits and Administration area in our base solution. evoBrix X custom loads other flexible and variable rates and can support the contractual agreements between the Agency and its partners. Team

CNSI's evoBrix X Core Claims solution accepts feeds from CMS and other approved sources on code sets. Major reference codes include:

- CPT4 procedure codes
- Modifiers
- ICD-10 Diagnosis and procedure codes
- DRG codes
- APC codes
- Revenue Codes
- HCPCS codes
- Revenue code/HCPCS relationships

Additional Solution Attributes

- ***Reference Support for Claims Pricing:*** Team CNSI's solution is configured to use provider-specific rates or provider contracts during the pricing of claims, if these rates are available. If these rates are not available, reference prices are used for pricing the claim. Our solution's framework not only supports the claims pricing based on the flat rates (code rates, provider specific rates, or specialty rates), but also based on specific modifiers. The Interface framework on our solution supports the interface feeds for the rates and relative value units as well. The claims adjudication process leverages the modifiers (e.g., bilateral modifier, pre, intra, post modifiers) submitted on the claim to price it differently.
- ***Indicators Related to TPL Processing:*** Team CNSI's solution is pre-loaded with a wide variety of TPL edits as part of its overall library of claims adjudication edits. These edits are configured in RuleIT, our configurable rules engine. The RuleIT composer will be used to implement the edits, including specific claim-level attributes such as trauma indicators and ICD-10 external cause codes submitted as the primary diagnosis on the claim. As is the case with all other categories of claims adjudication edits, TPL edits are associated with exception codes that indicate the reason why the edit failed.
- ***Benefit Plans:*** Team CNSI's solution provides the functionality to establish, view, and maintain benefit plans. It offers online screen functionality to define the category of service through procedure codes, diagnosis codes, benefit limitations, provider exclusions, eligibility criteria, effective dates, and member cost sharing. Through online screens, authorized users can make timely changes to the plan information and offer the flexibility for the Agency to reduce or add services, define monetary limitations, or impose premium and co-pay restrictions.

Figure 3.10.14-28 provides a screenshot of the different codes and referenced file data that can be managed.

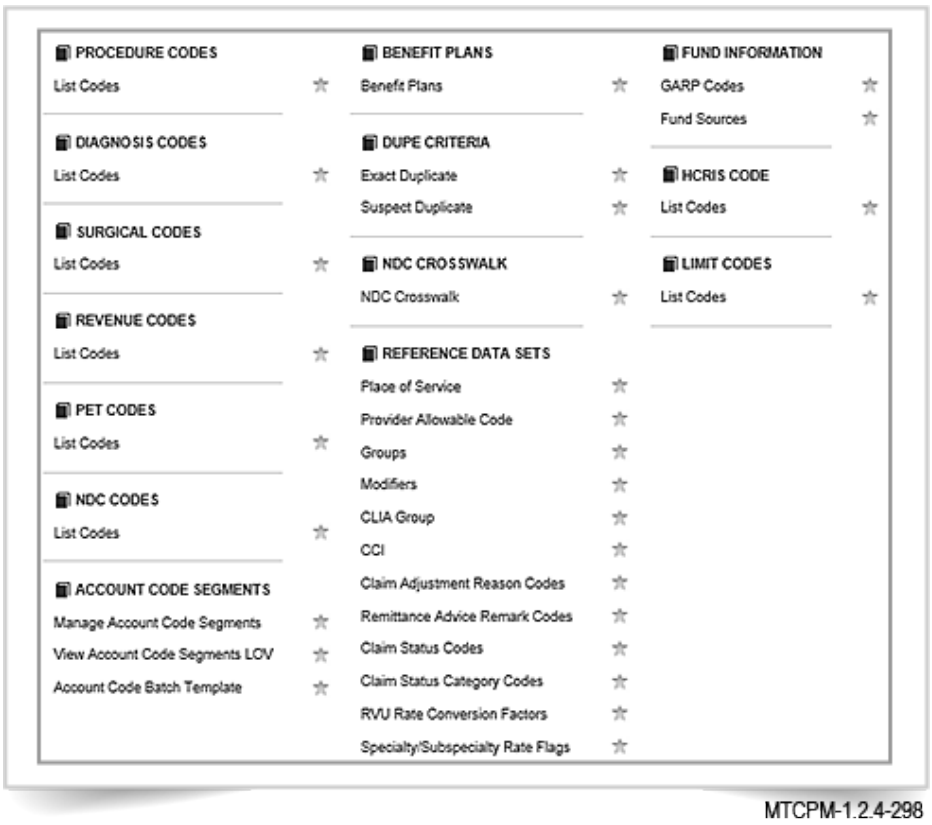


Figure 3.10.14-28. Management of Reference Files. Our evoBrix X solution can store and maintaining different codes and reference file data.

SAO37

The Contractor's Electronic Data Interchange solution shall provide the ability to support the exchange of EDI transactions with multiple distinct segregated testing environments with the full functionality of the production environment (including transaction processing, editing, validation, and reporting). The EDI solution will have the capability to create, update, and maintain X12 transactions (i.e. 834, 837, 270/271) as part of targeted testing scenario groups to support comprehensive system wide regression testing across all claim types, eligibility groups, and provider types as defined by the Agency. Following the execution of each EDI regression test group, Contractor will perform automated reconciliation between the test outcomes and the expected outcomes. Whenever possible, EDI regression tests should utilize real production transactions and outcomes for EDI regression tests.

Team CNSI's evoBrix X CPMS solution provides user-friendly interfaces and supporting business operations for claims submitted on the self-service portal through direct data entry (DDE) and 837 file uploads, batch submission through the electronic data interchange (EDI) Gateway, as well as paper claims submission. Team CNSI's evoBrix X CPMS solution accepts or generates published healthcare standard X12 files, including HIPAA837 P/D/I7, 27 I/O, 270, 271, 276, 277,277 U, 835, 834, 820,824, 997, 999 andTA17. Team CNSI's Medicaid claims processing solutions in Michigan and Washington support EDI transactions using these X12 file formats. Team CNSI understands the importance of EDI transactions and successful validation of the claims received through EDI files. It is important for our solution to validate all the claims and load the valid claim to the database tables to facilitate claims adjudication. Team CNSIunderstandsf the inconvenience caused to the provider when a valid claim fails the EDI validations due to inappropriate EDI edits. In order to ensure that all the valid claims are loaded to the database, Team CNSI establishes B2B and UAT test environments to allow providers to load the EDI

files manually or through batch to review the file validations in the new system. Providers can upload any existing EDI files (presumably which were already uploaded in the legacy system) and ensure that the results are same in the new system. These test environments will mirror the production environment and the provider and DPHHS can validate various EDI file transfer scenarios to ensure that file loading, processing, and validation are efficiently handled in the evoBrix X CPMS solution before running EDI exchanges in production.

SAO38

The Contractor shall establish and operate a mailroom for the intake of physical correspondence (e.g., scanning, batching claims, claims and attachments, faxes, adjustments and/or voids, medical records, appeals and grievances, letters, documents, surveys, returned mail) and processing and mailing of outbound physical correspondence (e.g., claims that fail prescreening, letters, documents, surveys, handbooks, mass mailings) including producing mailing labels.

Team CNSI will provide the inbound mailroom and outgoing mail house. These processes will be integrated through the use of ConnectionPoint. ConnectionPoint initially processes all image metadata, links documents to cases, and tracks all incoming and outgoing documentation by case record. Team CNSI will use ConnectionPoint to create all mail files for outgoing mail, including correspondence which requires references to received documentation such as claims that fail prescreening and require additional information.

Mailroom (Incoming Mail). Team CNSI offers complete receipt, sorting, physical inspection, imaging, and indexing of all received documents, mail, and fax as described in the response to Requirement ECM01. We will forward misdirected mail and process returned mail according to procedures documented during implementation and approved by the Agency. If approved, our mail house will use the United States Postal Service (USPS) address correction service to either automatically forward or simply report new addresses for additional verification according to the needs of the Agency. Team CNSI will recommend best practices for returned mail communication and follow-up for Agency approval.

Mail House (Outgoing Mail). Team CNSI works with a leading customer engagement fulfillment vendor, CSG International, for all outgoing physical mail. CSG, formerly Business Ink, has been a proven partner with Team CNSI for more than 20 years and has mailed millions of customized and information sensitive notices and letters for Team CNSI projects including the Texas Eligibility Support Services Project. Together, Team CNSI and CSG have established proven quality control and quality assurance mechanisms including continuous reconciliation of letter request files with print and mail confirmations, physical monitoring, weekly reports, and monitoring and correction for error trends. The CSG process meets ISO 9001:2008 standards for quality. CSG is also a Top 10 USPS First Class mailing producing more than one billion printed documents each year.

Our processing and printing capabilities eliminate the need for mailing labels as each letter, document, correspondence, and printed envelope will be customized and unique to the recipient. Team CNSI will work with the Agency to identify, test, and approve any customizable fields, potential display options, and templates prior to the first mailing. CSG will use industry- leading quality print-on-demand for all mass mailings, including handbooks, unless printed materials are specifically provided by another printer through the Agency.

SAO39

The Contractor shall provide a courier to pick up and drop off mail at the Agency designated USPS facility including delivering provider correspondence, administrative mail, and other non-claims mail to the appropriate functional areas (e.g., Agency staff).

Team CNSI will engage a bonded courier to transport outgoing mail to the Agency designated USPS facility and pick up incoming documents and correspondence, as required. Typically, our mail house service, CSG, makes specific arrangements with the USPS for bulk outbound mailing delivery, sometimes more than once per day depending on requirements and volume. Through CSG, we also subscribe to the USPS National Change of Address Service. We will use this service only as approved by the Agency. For incoming mail, our mailroom initially sorts all received mail and separates misdirected mail for forwarding to the appropriate state agency or resource.

SAO40

The Contractor's solution shall test all current and future HIPAA transaction processing according to guidelines developed by the Strategic National Implementation Process as defined by the Agency (e.g., compliance testing; application, operations, and interface testing; business to business testing).

CNSI's evoBrix X CPMS solution includes Edifecs XEngine for HIPAA validations and performs seven levels of editing as outlined below. These edits are per Strategic National Implementation Process (SNIP) guidelines. Team CNSI recommends Levels 1 and 2 be mandatory while the remaining are optional. EDI files that fail in Level 1 and/or Level 2 validation are rejected at the Transaction Set (TS) level rather than the Functional Group (GS) level. This ensures that, rather than rejecting all the business units within the GS, the number of business units rejected is kept to a minimum. The following provides a summary of the seven levels of editing performed by our solution:

- Level 1: Integrity Testing
  - Testing valid segments
  - Segment order
  - Element attributes
  - Testing numeric or alphanumeric data elements
  - Validating X12 syntax and compliance with X12 rules
- Level 2: Requirement Testing

Testing national implementation guide-specific requirements (e.g., repeat counts; used and unused codes, elements, and segments; required or intra-segment situational data elements such as non-medical code sets as laid out in the implementation guide; and values noted via an X12 code list or table)

- Level 3: Balancing
  - Testing field totals
  - Record or segment counts
  - Financial balancing of claims or remittance advice
  - Balancing summary fields
- Level 4: Situational Testing
  - Testing of specific inter-segment situations (e.g., if the transaction is an inpatient claim, a date of admission must be present)
  - Testing for situational elements in the State implementation guide

- Level 5: Code Set Testing
  - Testing for valid code set values and conformance (e.g., CPT, CDT3, NDC, ICD9, ICD10)
- Level 6: Line of Business Testing
  - Specialized testing required by certain health care specialties, such as chiropractic, ambulance, and durable medical equipment
  - Specialized testing for each line of business or provider class
- Level 7: Trading Partner Testing
  - Edits according to implementation guides that are unique and specific to a payer (e.g., Medicare, Medicaid)

SAO41

The Contractor's shall create materials at a reading level and for a culturally diverse population in a language or format (e.g., Braille, large-fonts, recordings) preferred by the intended recipient (e.g., member, provider) as defined by the Agency.

Team CNSI will create materials per Agency direction for a culturally diverse population at an appropriate reading level and in the language and format that is most effective for the intended recipients. We will coordinate with the DPHHS to define specific material needs for either format (such as Braille, large print, recordings, etc.) or audience (member, provider, specific minority/ethnic/language, etc.). We follow industry standards for material creation. For example, Braille documents will be printed in Unified English Braille (UEB) which has been adopted as the international standard.

Team CNSI works with more than 20 federal and state clients to deliver culturally appropriate content through clear, easy-to-understand materials. To design the most effective and sensitive approach to consumer education, we are proud to offer our Center for Health Literacy as a value-added resource to the State. The Center for Health Literacy is unique to Team CNSI and is an industry leader in designing and promoting culturally and linguistically appropriate materials, web sites, notices, call scripts, customer surveys, and other written materials for various populations seeking health care services. The Center for Health Literacy has designed brochures, forms, web sites, and other materials for CMS, the EPA, and many State programs, including for the six State Based Exchange call centers Team CNSI has operated. The Team CNSI Center for Health Literacy empowers consumers by simplifying the language in outreach and education materials

Plain Language Health Literacy. The Center brings unmatched experience in providing plain language, usability and readability to healthcare materials. We have helped improve government health program materials across the country, including advising CMS on the planning, design and draft content development for the federal online and paper-based Model Single Streamline Application. In addition, the Center has been awarded three ClearMark Awards of Distinction for plain language and clear communication in content, in 2017 and 2018. The Center will advise our Montana Team to confirm all materials comply with plain language requirements.

Member or Provider Focus. We will develop all materials with a member or provider focus in mind. We assign each document a unique code for initiating mailing or faxing through ConnectionPoint.

Format. Team CNSI can provide materials in a member or provider's preferred alternative format including audio, Braille, large print, and text-only Word documents. We will develop all materials, including large-font materials in all languages, as required to meet the CMS Final Rule CFR 42, §438.10, upon implementation of the CMS Final Rule. Team CNSI will comply with Section 508 ADA and ADA 42 U.S.C., Section 12101 et. Seq. in the production and distribution of all required materials. We will

provide appropriate instructions on how to access or receive assistance with accessing desired materials in an alternative format.

Translation. The Center regularly assists Team CNSI call centers with materials translation, most commonly in Spanish, in order to confirm the translated materials, continue to meet the health literacy standards established for the English language version of each document. When necessary, Team CNSI can pass all documentation to an independent third-party translator, U.S. Translation, for validation of sensitive materials with an anticipated wide distribution.

SAO42

The Contractor shall not require travel by Agency staff outside of the primary project location to support contract activities, as defined by the Agency.

Team CNSI will use our facility in Helena, MT as the primary project location for any contract activities that require Agency staff on-site. Other work on the contract will be performed at various Team CNSI locations, but Agency staff will not be required to travel to those locations.

SAO43

The Contractor's solution shall provide a configurable dashboard to display transaction activity (e.g., average processing time and transaction volume) as defined by the Agency.

The evoBrix X CPMS solution includes HealthBeat, a dashboard tool for transparency and visibility into Medicaid operations. HealthBeat is a robust, automated framework that allows users to extract, analyze and report data across a broad range of business processes, transactions, and activities as shown in Figure 3.10.14-29. This allows users to visualize transaction activity, performance monitoring and trigger performance improvement actions or corrective action plans. HealthBeat dashboards provide information on post payment summaries and Remittance Advice so that they can be analyzed for identifying unusual trends. These reports and dashboards are updated periodically based on payment cycle completion to reflect the updated numbers. HealthBeat can be configured on a user-by-user basis to present information that is critical to each specific user. HealthBeat is available in its native web application format, as well as in a mobile application supporting iOS iPAD and Android tablets.



Figure 3.10.14-29. HealthBeat Claims Business Operations Dashboard. Team CNSI's HealthBeat provides DPHHS with near real-time metrics and full transparency into the program.

SAO44

The Contractor shall create and maintain the comprehensive conceptual, physical, and logical data model for all data throughout the life of the contract as defined by the Agency.

Team CNSI will create and maintain conceptual, physical, and logical data models for all data throughout the life of the contract. Our data models are expandable and allow incremental addition of component and interfaced system data items. Data modeling is managed via the industry standard ERwin Data Modeler. Team CNSI's solution is designed on an integrated normalized data model as a single point of access to handle the relevant transactional and operational data during DDI and operations and maintenance. The normalized data model not only determines the structure and flow of data in the solution, but also ensures that the data that moves into the system is consistent in terms of business relevancy, data format, and other data semantics. The normalized data model helps in maintaining data quality by avoiding redundancy in transaction processing and helps re-use of the data using referential linkage (query joins) The module has a robust baseline information architecture and has the right data management strategy to manage the changes typically associated with health care regulations and reforms. The model is an abstract formalization of objects and their relationships within the system to ensure cross-referential integrity across diverse business process areas to prevent data inconsistencies. The tool also provides a data dictionary. The data dictionary is defined and maintained as part of the evoBrix X physical data model, and is always in sync with the database, ensuring any data element change in the system is captured. In addition, the System Architecture diagrams document the technologies, protocols, and any security controls implemented when the data is traversing through various network boundaries.

The evoBrix X Core Claims module includes data items, such as provider, recipient, claims processing, and other data, to support Agency management reports and analyses. Since the data model is scalable, it can accommodate any additional data elements introduced due to changes in existing processes, new functionalities, and new interfaces from component and interfaced systems. Team CNSI utilizes the concept of flexible (flex) fields to handle new element additions and customization, reducing the changes to the underlying code. Team CNSI team will define what those flex fields should store based on the Agency's business needs (i.e., defining the meta-data details), whether they should be mandatory or optional, the formats/lengths/ precision/scale, the default value (if any), and the order in which the flex fields are to be displayed. This approach enables us to maintain a single physical data model and reduce the cost of operations and maintenance over the life of the system.

SAO45

The Contractor shall allow the state to purchase software licenses and software maintenance directly, if determined to be in the best interest of the Agency, for use within the solution as defined by the Agency.

Team CNSI will allow DPHHS to purchase software licenses and software maintenance directly if doing so is in the best interest of the Agency. Team CNSI maintains all COTS products integrated with our solution in such a way so that changes and updates to those products are tested prior to rolling out updates to ensure that functionality or system performance is not impacted. In the event that the State elects to purchase COTS products used within the evoBrix X CPMS solution directly, we will collaborate with the State to define the best process to ensure that any changes to the licenses, or maintenance of the underlying product does not adversely affect the solution.

SAO46

The Contractor's solution shall only utilize production data for testing with approval as defined by the Agency.

Team CNSI will use production data for testing with approval as defined by the agency. Team CNSI de-identifies production data if it is used in a development or non-production environment to support configuration, development, verification, testing, or other non-production activities. Data de-identification, alternatively referred to as anonymization or masking, is key for ensuring data privacy, confidentiality, and data protection. Team CNSI refreshes the data weekly with current production data to ensure testing is performed with the latest data. Our database refresh process is highly automated to maintain compliance with timelines and minimize any downtime.

SAO47

The Contactor's solution shall have the capability for use of the Web Portal to report fraud, waste, and abuse as defined by the Agency.

The evoBrix X CPMS solution provides the ability to report any Medicaid fraud, waste, and abuse by contacting the call center which is part of our Option B solution. Any communication once received will be automatically integrated with evoBrix X CRM solution and a case will be created for further investigation. Any additional information that is gathered is attached to the ticket and tracked it until closure.

SAO48

The contractor's solution shall have the ability for members to manage their account using a Web Portal (e.g., verify eligibility (request a replacement Medicaid ID card), view claims information, and file complaints) as defined by the Agency.

The evoBrix X CPMS solution includes myHealthPortal, a self-service web portal which allows users to review their account and benefits (e.g., verify eligibility), request a replacement Medicaid ID card, receive REOMB, view claims information, and file complaints. The solution provides a user-friendly interface to allow members to perform the following:

- Check eligibility related to covered benefit plans, and specific services for which the member is eligible.
- Request coverage information under benefit plans.
- Request Medicaid ID cards via View Medicaid Card and "Request New/ Replacement Medicaid Card" features, and Members can view status and history of all requests (as shown in below).
- Send questions to Ask MPATH Medicaid, in which the member will be able to submit a new question, view list of submitted questions, submit complaints and view the available replies.

Figure 3.10.14-30, Figure 3.10.14-31, Figure 3.10.14-32, and Figure 3.10.14-33 provides sample screens from myHealthPortal.

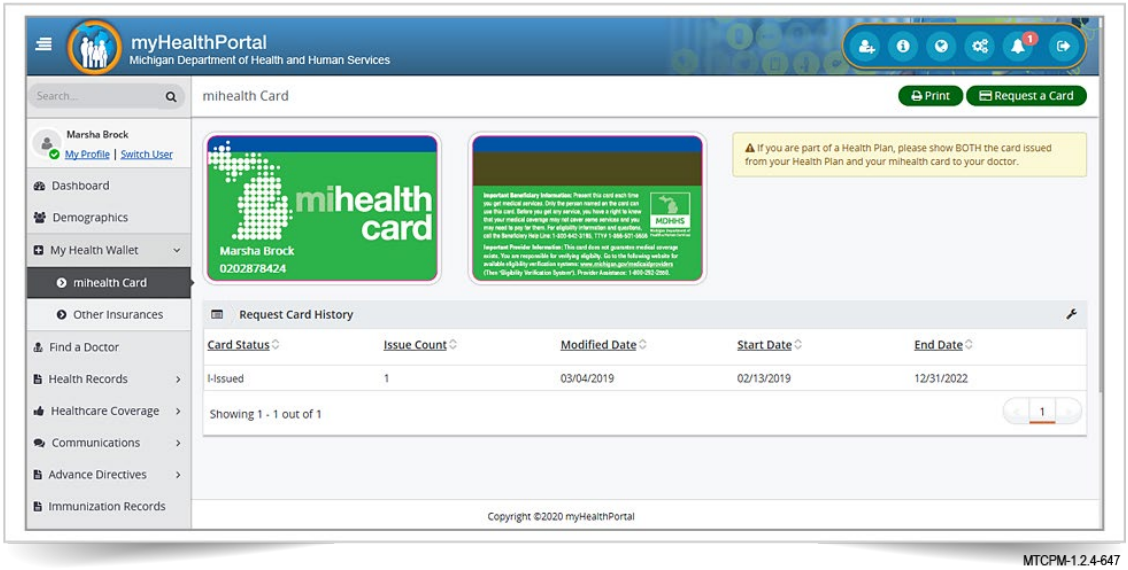


Figure 3.10.14-30. myHealthPortal Screen 1. myHealthPortal provides Medicaid members access to a wide range of information related to their healthcare and coverage through a web portal.

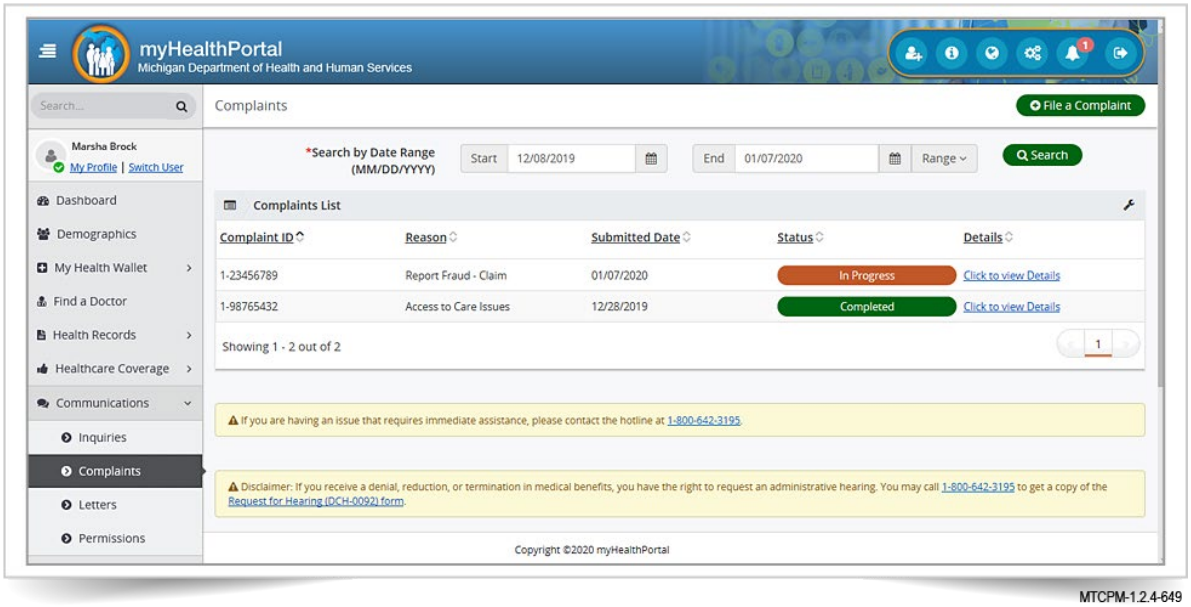


Figure 3.10.14-31. myHealthPortal Screen 2. myHealthPortal provides Medicaid members access to a wide range of complaint information related to their healthcare and coverage through a web portal.

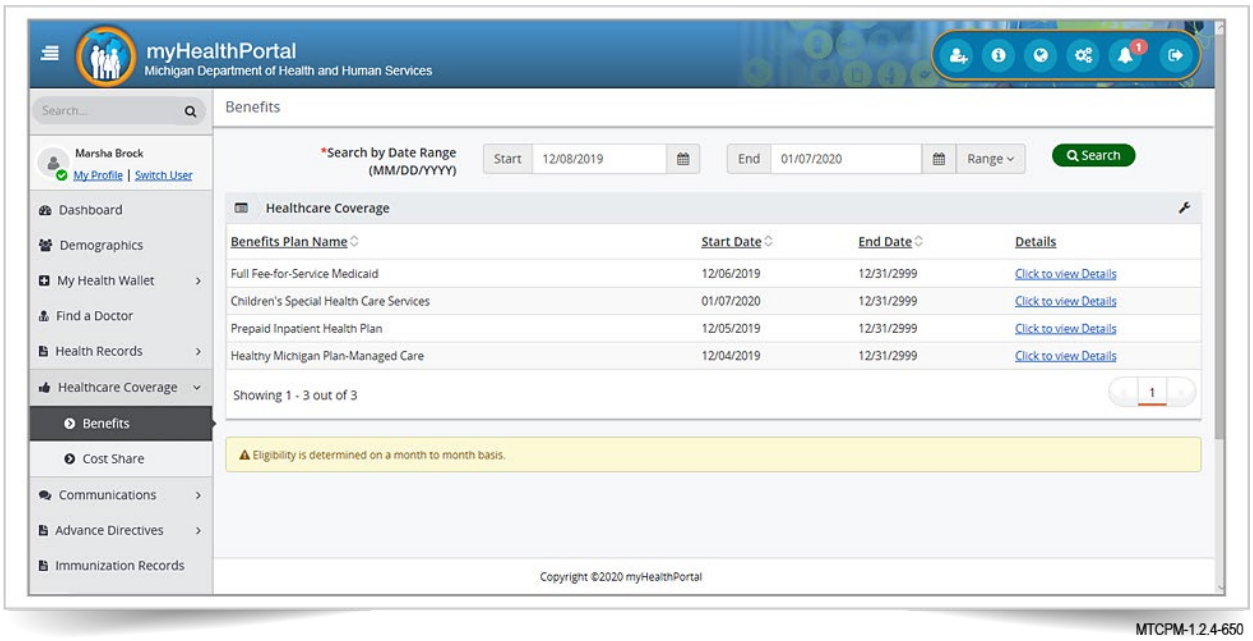


Figure 3.10.14-32. myHealthPortal Screen 3. myHealthPortal provides Medicaid members access to a wide range of complaint information related to their healthcare and coverage through a web portal.

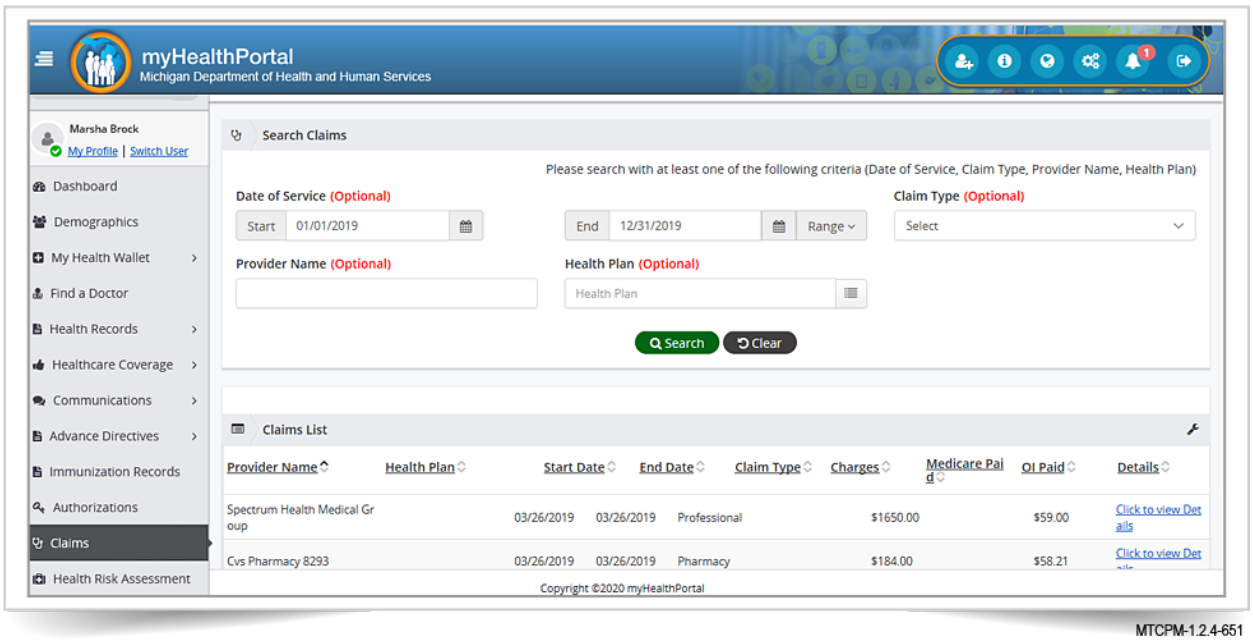


Figure 3.10.14-33. myHealthPortal Screen 4. myHealthPortal provides Medicaid members access to a wide range of complaint information related to their healthcare and coverage through a web portal.

SAO49

The Contractor shall supply staff to analyze, develop, and configure payment methodologies and coordinate with Agency staff during rule and policy changes as defined by the Agency.

Team CNSI has the domain expertise within our project staff to support analysis, development, and configuration of payment methodologies and coordinate with Agency staff during rule and policy

changes. The information captured in providing this support will be made available as part of the appropriate Detailed System Design Documents.

SAO50

The Contractor's solution shall provide a web portal with the ability to upload forms and supplemental claim documents (e.g., primary payer EOB, medical records, contractor published documents, requests for information) and automatically associate the file to the claim or member record, as defined by the Agency.

Team CNSI's Document API Service solution provides an automated feature for providers to transmit documents to support the claims adjudication process. The solution provides multiple options for users to upload and associate attachments. With the use of an upload attachment functionality, authorized users can upload the documents using the web portal screens and have the flexibility to retrieve the attachment to perform their work functions.

Document API Service maps the documents to respective transactions and stores them in the document repository. evoBrix allows edit processing to consider the existence of attachments sent by the submitter as part of a business rule. Figure 3.10.14-34 shows the capability to display all attachments received for a claim.

Figure 3.10.14-34 shows the capability to display all attachments received for a claim.

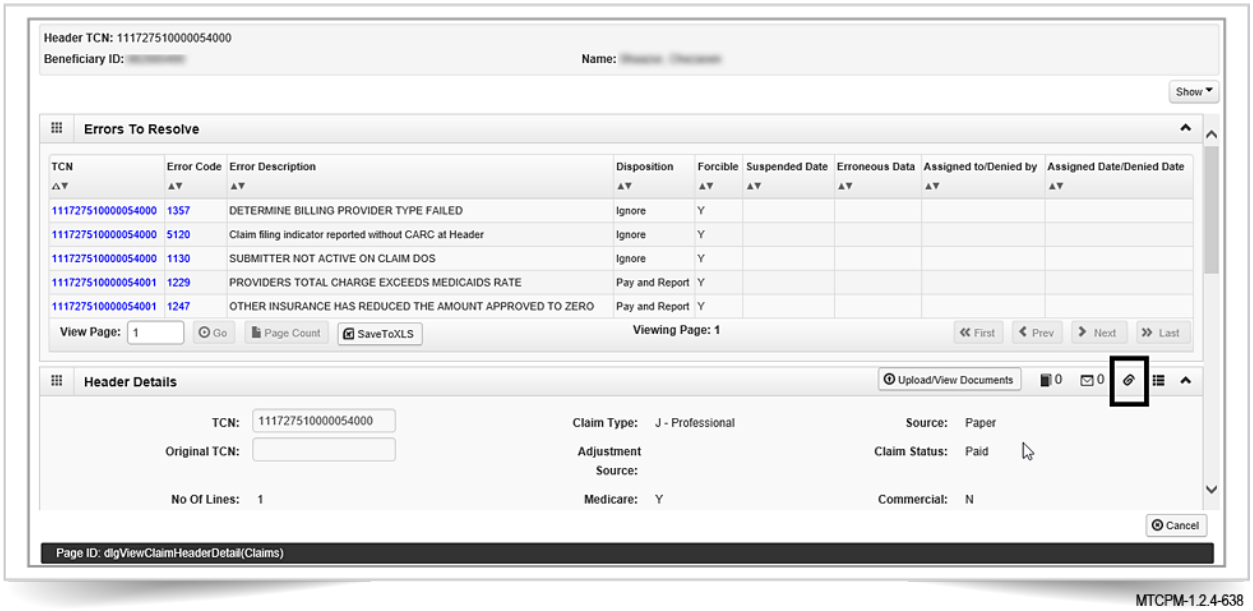


Figure 3.10.14-34. Claims Screen Linking Claim to an Attachment. Displaying the attachment along with claims data in the screens improves user friendliness and increases the productivity of operations and fiscal agent personnel in adjudicating a claim.

SAO51

The Contractor's solution shall process the following transactions: 837I Healthcare Claim: Institutional 837P Healthcare Claim: Professional 837D Healthcare Claim: Dental 835 Healthcare Claim Payment/Remittance Advice 270 Eligibility, Coverage, or Benefit Inquiry 271 Eligibility, Coverage, or Benefit Information 276 Healthcare Claim Status Request 277 Healthcare Claim Status Response 278 Healthcare Services Review – Request and Response 820 Premium Payment 834 Benefit Enrollment and Maintenance 997 Acknowledgement 824 Application Advice.

Team CNSI's evoBrix X CPMS solution is HIPAA/HITECH and ASC X12 5010 compliant and is based on systems that have been previously been certified by CMS in Michigan and Washington where it has been serving the Medicaid population for over a decade. Figure 3.10.14-35 provides a summary of the volume of transactions in our production systems over the past decade.

Transaction Name	Processing Mode	Transaction/Day
270/271	RealTime	480,000
270/271	Batch	100,000
837		

Figure 3.10.14-35. Transaction Statistics. Team CNSI evoBrix X CPMS X 12 transaction framework has been successfully processing EDI transactions in both Michigan and Washington for over a decade.

Team CNSI has extensive experience in implementing X12 version 5010 and interacting with providers, clearing houses, and third-party vendors using the following HIPAA transactions as required by 45 CFR Parts 160 and 162:

- 270 – Eligibility, Coverage, or Benefit Inquiry
- 271 – Eligibility, Coverage, or Benefit Information
- 276 – Electronic Claim Submission System Request
- 277 – Electronic Claim Submission System Response
- 835 – Healthcare Claim Payment Advice
- 837D – Healthcare Claim — Dental
- 837I – Healthcare Claim — Institutional
- 837P – Healthcare Claim — Professional 999 – Functional Acknowledgment
- TA1 – Interchange Acknowledgment
- 278 – Prior Authorization Request
- 278 – Prior Authorization Response
- 834 – Benefit enrollment and maintenance
- 820 – Premium Payments997 - Functional Acknowledgment
- 824 - Application Reporting
- 277U- Health Care Claim Status Notification - Health Care Payer Unsolicited Claim Status



The solution accepts HIPAA transactions using the CAQH CORE Phase III compliant EDI Integration Gateway and the EDI File Upload feature from evoBrix X Core Claims module screens.

SAO52

The Contractor's solution shall accept, screen, date-stamp, assign unique control numbers, and store hard copy all claim forms and attachments.

Team CNSI uses high-speed scanners to produce images of hard copy documents. As part of the imaging process, a unique transaction control number (TCN) is assigned to each claim or piece of correspondence and printed on the physical document. Once scanned, the image is saved and uploaded into the ECM (i.e., FileNet). Team CNSI limits risk of any misplaced documents by completing a documented physical review of all work areas and workstations as part of the end-of-shift procedure. Any exception discovered is documented as a finding on the daily report, along with the corrective action taken.

Team CNSI will maintain a claims control and inventory system. All claims are subject to counting, balancing, and reconciliation procedures through every step of processing from receipt through final adjudication. The TCN identifier assigned to the document is the means of both retrieving the document and related documentation to allow for processing and status reporting throughout the claim life cycle. Attachments receive the same unique identifier as the primary document to allow all related documents to be retrieved as a unit.

It is Team CNSI's standard practice to stamp all incoming documents and correspondence with the date received for tracking and entry into the ECM. Team CNSI staff will sort documents into batches, each with a unique document and batch identification number. Workers will use separator sheets between documents for additional quality control. After scanning, Team CNSI will keep hard copy documents in their respective envelope sets and batches for easy retrieval and store in a secure, locked facility until the required document retention date has passed. The ECM immediately assigns a unique control number to each document upon scanning which follows the document throughout the process.

SAO54

The Contractor's hosting environment for all module components shall be compliant with Statement on Standards for Attestation Engagements (SSAE-18) SOC 2 Type 2 and has Federal Risk and Authorization Management Program (FedRAMP) Certification, FedRAMP Risk Assessment that indicates compliance, or has a documented NIST 800-53 rev 4 at a "moderate" system risk assessment designation. If the Contractor proposes either a multi-tenant solution or a public cloud, hybrid cloud (Service (SaaS), Platform as a Service (PaaS), and Infrastructure as a Service (IaaS)), or community cloud environment, the vendor must ensure that the environment is either FedRAMP certified or that the shared resources are only accessible by HIPAA-covered entities as defined in 45 CFR 160.103.

Team CNSI is proposing to host the evoBrix X Claims Processing module in AWS FedRAMP Moderate-compliant public cloud. The primary AWS data center will be in Oregon with various availability zones. These data centers utilize a robust and redundant infrastructure architecture to provide maximum uptime for critical data, applications, and technologies. In addition, these data centers provide managed services that are anchored in world-class secure data center facilities with best-of-breed infrastructure and highly robust network architecture. All infrastructure components including servers, network, storage, backup storage, and firewalls are hosted in HIPAA-compliant and FedRAMP-compliant data centers.

SAO55

In the event the Contractor is unable to continue meeting the requirements for the approved hosting model or if the Contractor desires to transition to different hosting model that is compliant with the requirements of the contract, the Contractor must: 1) provide the state with the opportunity to verify compliance of the new hosting environment with the contract requirements in advance of transition, 2) ensure that there is no additional cost to the state for the new hosting model, and 3) ensure that there is no disruption of service to end users as a result of the transition.

Team CNSI proposes to host the evoBrix X Claims Processing module in AWS FedRAMP Moderate-compliant public cloud. If Team CNSI desires to or is required to transition to a different hosting model, we will coordinate this effort with DPHHS to ensure that:

- DPHHS has sufficient advance notice to verify compliance of the new hosting environment with the contract requirements;
- Cost to DPHHS will be no greater than what is currently included as costs for our proposed hosting model; and,
- All migration activities will be carefully planned and performed so that there is no disruption of service to end users.

SAO56

The Contractor's solution shall receive, store, create, and maintain an indicator and effective dates of an enrolled provider's participation in state specific programs (e.g., health home, primary care enhanced rate) as defined by the Agency.

Team CNSI's evoBrix X CPMS solution can automatically receive, store, create, and maintain an indicator that provides details on an enrolled provider's participation in state specific programs, as shown in Figure 3.10.14-38. The system also allows DPHHS authorized users to manually set indicators at location, tax identifier, and owner levels. These indicators are used to identify certain payment constraints, Managed Care specifics, and enrolled vs. non-enrolled providers.

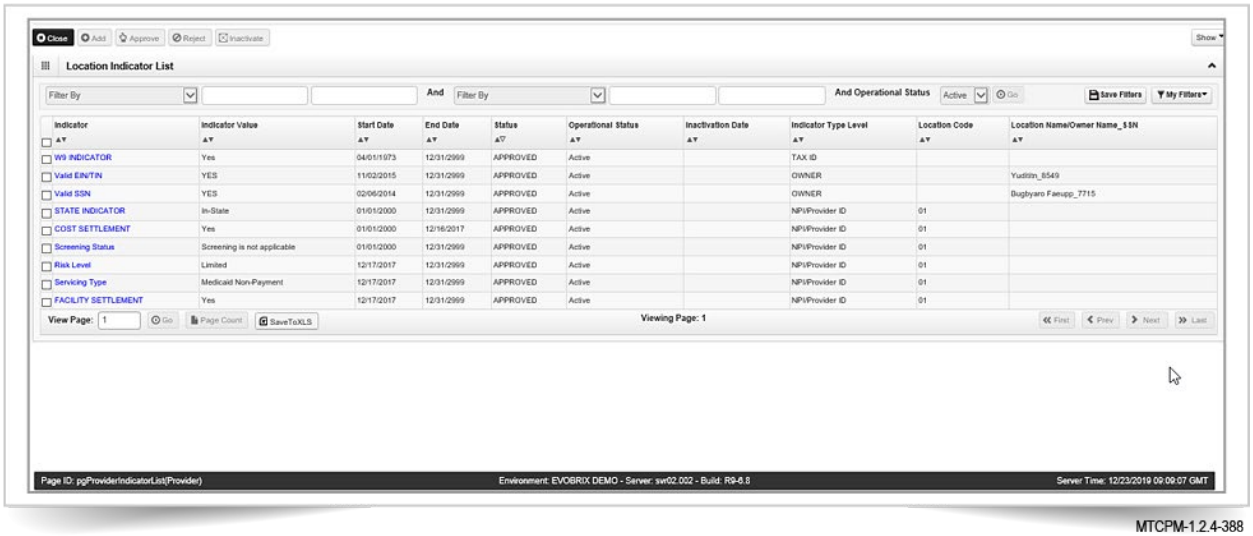


Figure 3.10.14-38. Provider Participation in State Specific Programs. Team CNSI's solution captures provider participation in state specific programs and indicators.

SAO58

The Contractor's solution must evaluate criteria defined by the agency (e.g. provider participation flags for specified programs) to adjudicate claims and established pricing.

Team CNSI's evoBrix X Core Claims module can be configured to allow the Agency to set a checklist of questions and a corresponding rules workflow that allows for automated evaluation of Agency-defined criteria to determine if a provider is eligible to participate in state specific programs. Team CNSI's evoBrix X Core Claims module leverages the edit logic through our RuleIT rules engine to support claims adjudication and pricing. By configuring the edit rules, the system can determine if claims criteria are met, and, if not, can post the appropriate edit. The solution also allows DPHHS authorized users to manually set indicators at location, tax id and owner levels. These indicators are used to identify certain payment constraints, Managed Care specifics, and enrolled vs. non-enrolled providers. The evoBrix X Core Claims module claims adjudication validates the provider programs and the provider rates established in reference rates and price the claim accordingly. Team CNSI's evoBrix X Core Claims module leverages the edit logic through our RuleIT rules engine to support claims adjudication and pricing. By configuring the edit rules, the system can determine if claims criteria are met, and, if not, can post the appropriate edit. The solution also allows DPHHS authorized users to manually set indicators at location, tax id and owner levels. These indicators are used to identify certain payment constraints, Managed Care specifics, and enrolled vs. non-enrolled providers. The evoBrix X Core Claims module claims adjudication validates the provider programs and the provider rates established in reference rates and price the claim accordingly.

Team CNSI's evoBrix X Core Claims module leverages the edit logic through our RuleIT rules engine to support claims adjudication and pricing. By configuring the edit rules, the system can determine if claims criteria are met, and, if not, can post the appropriate edit. The solution also allows DPHHS authorized users to manually set indicators at location, tax id and owner levels. These indicators are used to identify certain payment constraints, Managed Care specifics, and enrolled vs. non-enrolled providers. The evoBrix X Core Claims module claims adjudication validates the provider programs and the provider rates established in reference rates and price the claim accordingly.

SAO59

The Contractor's solution shall validate that the member is assigned to the provider and has active eligibility for the period prior to payment.

Team CNSI's evoBrix X Core Claims module allows the authorized Providers to enter member admission details through online screens for Long Term Care programs such as Nursing Facility, Psychiatric facilities, Hospice and Home and Community based services. Our solution derives the Program Enrollment Type and assigns the corresponding benefit Plan along with the Provider/Facility to the member. The solution has capabilities to capture Date of Admission, length of stay, and level of care required. Team CNSI's evoBrix X Core Claims module is preconfigured with nursing facility admission reviews for upfront editing during admission.

Subsequently, long-term care claims will be edited for matching active admission for member, Provider, member eligibility for nursing facility services, history, and duplicate claims check for continued stay claims processing as shown in Figure 3.10.14-39.

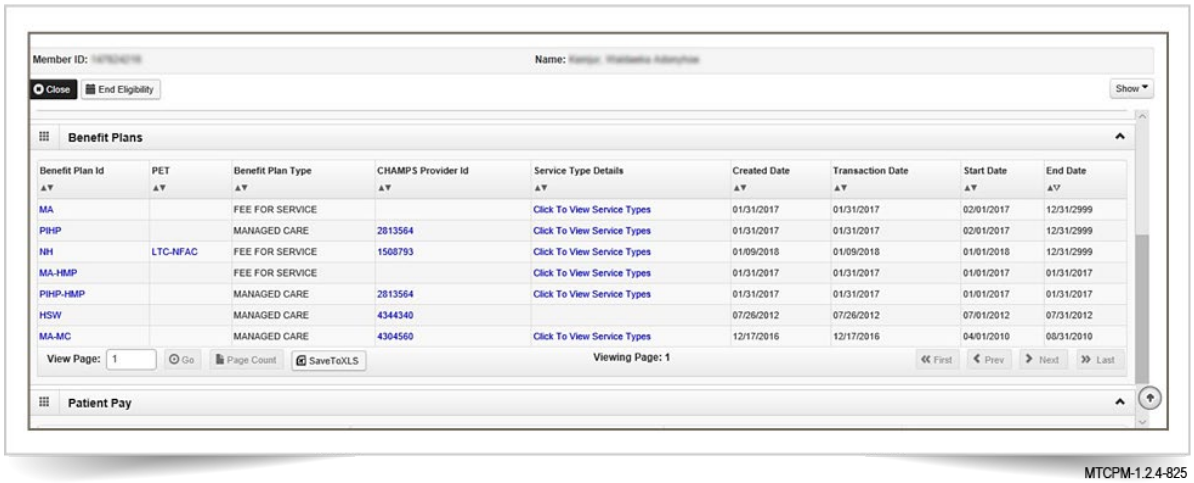


Figure 3.10.14-39. Member Benefit Plans. The long-term care benefit plan for the member associated with long term and nursing facility provider.

SAO64

The Contractor's claims processing environment will be sized to process up to 200 concurrent transactions per second.

Team CNSI's CPMS solution currently processes over 90 million claims and encounters per year and can process approximately 500 concurrent transactions per second. Based on this requirement, Team CNSI has sized our solution to process 200 concurrent claims transactions.

SAO65

The Contractor shall provide tools for comprehensive performance monitoring and reporting via a dashboard, for SLAs related to the claims processing and management services scope of work and performance of the claims solution.

The evoBrix X solution provides integrated tools and dashboards to monitor system, claims processing, and management services performance. This enables near real-time business and system monitoring with alerting using our HealthBeat tool. HealthBeat provides multiple dashboard views, business and system metrics, and an SLA performance monitoring dashboard. As shown in Figure 3.10.14-40, HealthBeat provides operational transparency and real-time data to stakeholders for validating operational performance and meeting program needs.



Figure 3.10.14-40. HealthBeat Claims Business Operations Dashboard. Team CNSI's HealthBeat provides DPHHS with near real-time metrics and full transparency into the program.

Team CNSI's SaaS delivery model transforms the MMIS of the past, from delivery of technology to delivery of services enabled by technology. We organize our operations teams around the catalog of services we expect to deliver in each business area, and we plug in and configure our solution's technology services necessary to perform the business services for that area. Effective service delivery requires continuous measuring, monitoring, and management to improve operational performance, transparency, and agility. Our management and monitoring tools enable us to manage service delivery as part of our ITIL operations framework. Additionally, our evoBrix X SaaS solution, built on components previously certified by CMS, is designed based on industry best practices and enhanced through years of experience in design and development of MMIS solutions in Michigan, Washington, Illinois, and Utah.

Team CNSI brings operations experience and lessons learned on every implementation, which will ensure successful transition of all required MPATH services. Our proposed evoBrix X CPMS solution is truly web-centric, configurable, and delivered through SaaS services. This combination of features is unique in the Medicaid environment. Not all solutions are equal, however; the majority in this environment are pairings of legacy components with shared infrastructure to form a "cloud" solution. Such an approach is not capable of delivering on the promise of a true SaaS model, especially in the critical areas of configurability, scalability, and extensibility.

SAO66

The Contractor must provide a secure communication mechanism that can be accessed by multiple vendors based on user role as defined by the Agency.

evoBrix X CPMS solution provides a secure Inbox to communicate with Providers and Members who are authorized to access the system. Whenever authorized users sign in, their inbox is displayed as shown in Figure 3.10.14-41. The inbox has announcements, alerts, and other reminders. The alert and notifications are delivered to the users via a secured message to their inbox within evoBrix X. It enables e-mail and inbox notification to be associated to an event and workflow. The alert type, along with the alert due data

reminds users which work items require their attention. Users can read, responds, forward and delete messages from My Inbox, once deleted they won't be shown to the user anymore in subsequent logins. These are shown to the users based on the user security profiles set up in the system.

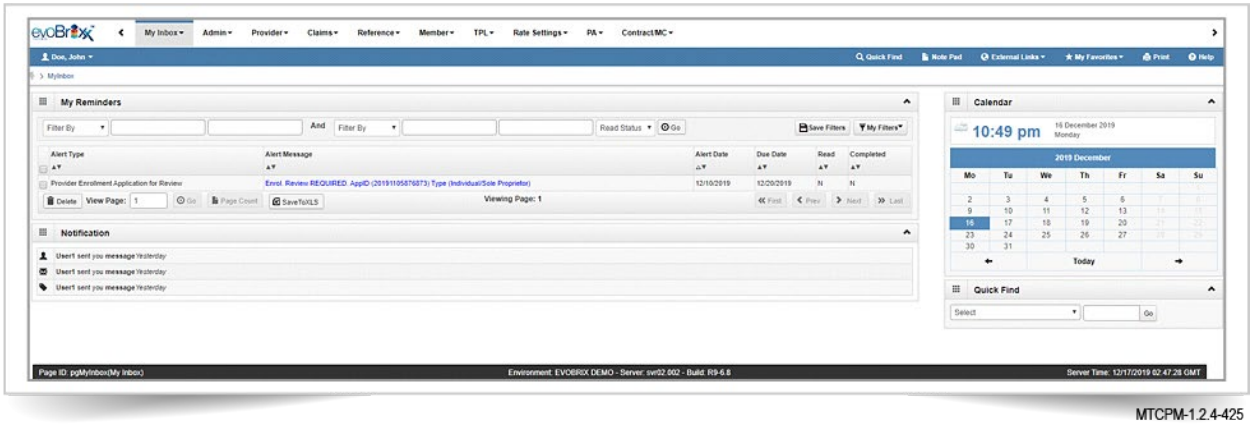


Figure 3.10.14-41. evoBrix X Secure Inbox. evoBrix X provides a secure inbox to ensure appropriate privacy based upon user security profiles configured in the system.

SAO67

To support exchange of data with the MMIS requested by other entities, the contractor shall establish network connections with other MMIS vendors or State trading partners as determined necessary by the State and shall host related hardware and software components to support secure network connectivity at a reasonable cost that is paid by the other MMIS vendors or trading partners and shall establish Interconnection Security Agreements that document interface characteristics, security requirements, and the nature of the information communicated over the connection

Team CNSI's CPMS solution includes a platform that establishes an interoperability layer that supports interactions among components via a variety of protocols. Team CNSI's solution employs several security measures to help ensure the authenticity, integrity, and privacy of data in transit. Our solution encrypts and authenticates all data in transit at one or more network layers when data moves outside physical boundaries. evoBrix X supports IPSec Transport mode/VPN Tunnel for secured end-to-end (Site to Site) communications, this allows the associated subsystem of claim's solution to connect to the network even when not directly connected to the network. In addition to site to site VPN tunneling, evoBrix X Solution supports both whitelisting and blacklisting which enhances the security and privacy of the entire solution. Figure 3.10.14-42 shows the evoBrix X solution connection with associated systems through VPN Tunnel.

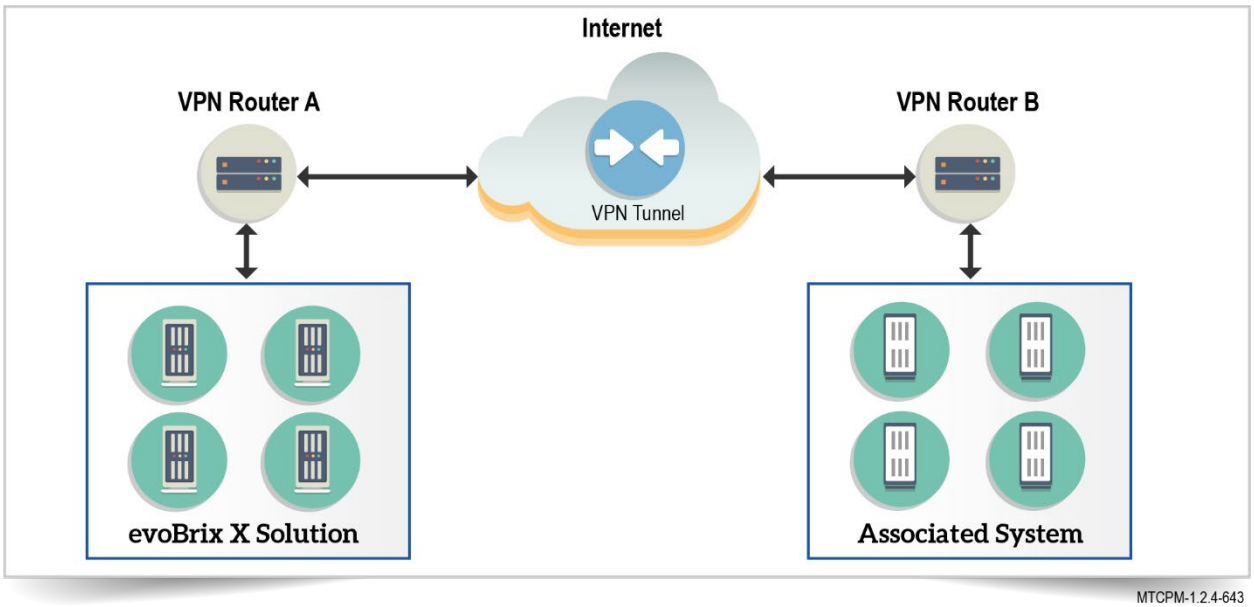


Figure 3.10.14-42. evoBrix X Connection Through VPN Tunnel. Our solution encrypts and authenticates all data in transit at one or more network layers when data moves outside physical boundaries.

SAO69

Contractor shall ensure that individuals occupying Key Personnel positions shall, at a minimum, provide services between 8:00 a.m. and 5:00 p.m. local time Monday through Friday unless a resource-specific alternative schedule is approved by the Agency.

All key personnel will be available 8:00am through 5:00pm local time, Monday through Friday. Key Personnel will also be made available at other times as required by Agency request or to support critical after-hours activities.

SAO70

The Contractor's solution shall allow authorized users to search and view Claims Based Medical History.

The evoBrix X CPMS solution provides comprehensive tracking of claims through the claim life cycle, from receipt of a claim via any source (i.e., DDE, EDI, or paper) through adjudication and final remittance advice. Using the various filter options on the Claims Inquiry screen, data can be queried to view the status of web-based claims. For example, users can locate all the claims that were submitted for a member by entering the member ID in the filter options. The search result will provide a holistic view of all the claims that were submitted for the beneficiary which in turn can be further analyzed to identify the medical history. Figure 3.10.14-43 shows the claims inquiry screen.

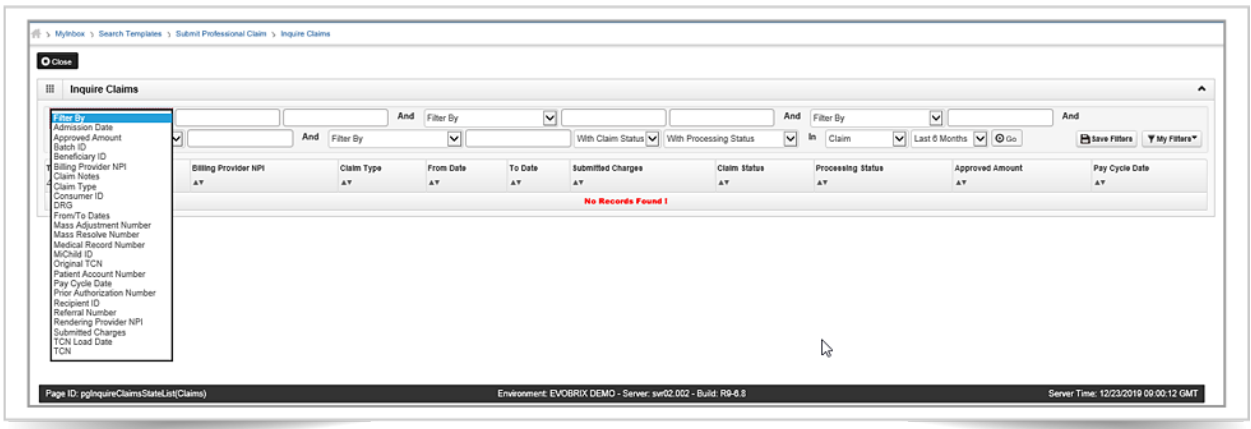


Figure 3.10.14-43. Search and View Claims using Claims Inquiry Screen. *The evoBrix X Core Claims module provides a flexible claims search capability via the claims inquiry screen.*

SAO71

The Contractor's solution shall include a self-service tool for providers to directly and efficiently enter claims.

Team CNSI's evoBrix X CPMS solution provides user-friendly interfaces and supporting business operations for claims submitted on the evoBrix X Core Claims module through DDE. The DDE method is typically utilized by providers who do not submit a large number of claims. DDE provides authorized providers the ability to directly key in a CMS-1500 Professional claim or a UB-04 Institutional claim or an ADA Dental claim from the portal into the evoBrix X Core Claims module. To ease the task of keying a claim into the Core Claims module directly, our solution provides screens that are similar to the CMS-1500 and UB-04 forms. Figure 3.10.14-44, Figure 3.10.14-45, Figure 3.10.14-46, Figure 3.10.14-47, Figure 3.10.14-48, Figure 3.10.14-49, and Figure 3.10.14-50 shows the DDE screens related to professional claims entry.

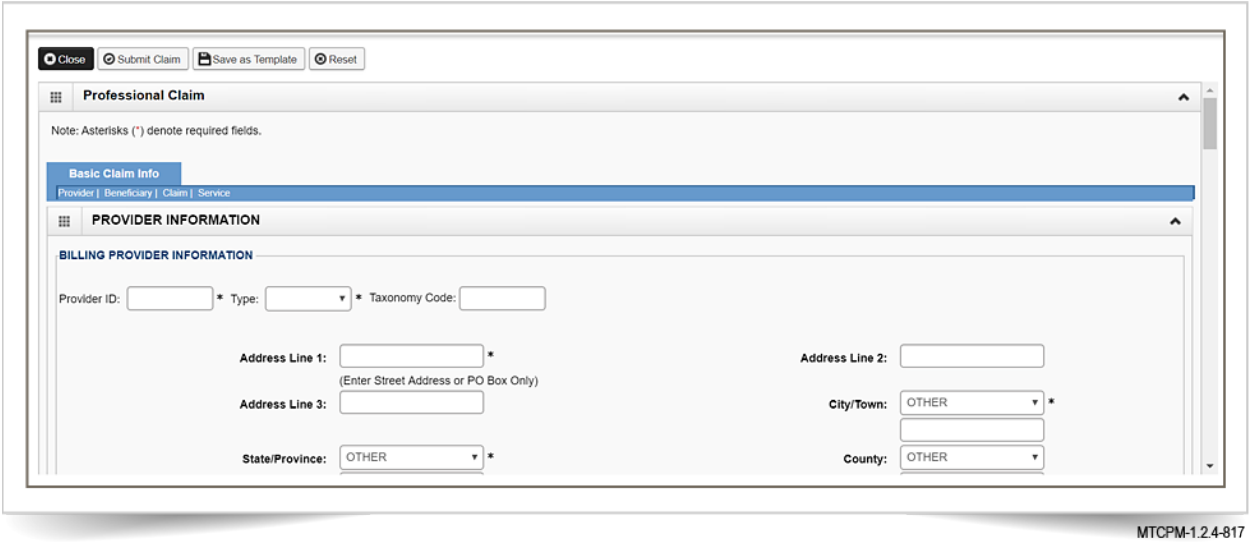


Figure 3.10.14-44. Professional Claim DDE Screen to Enter Provider Information. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.

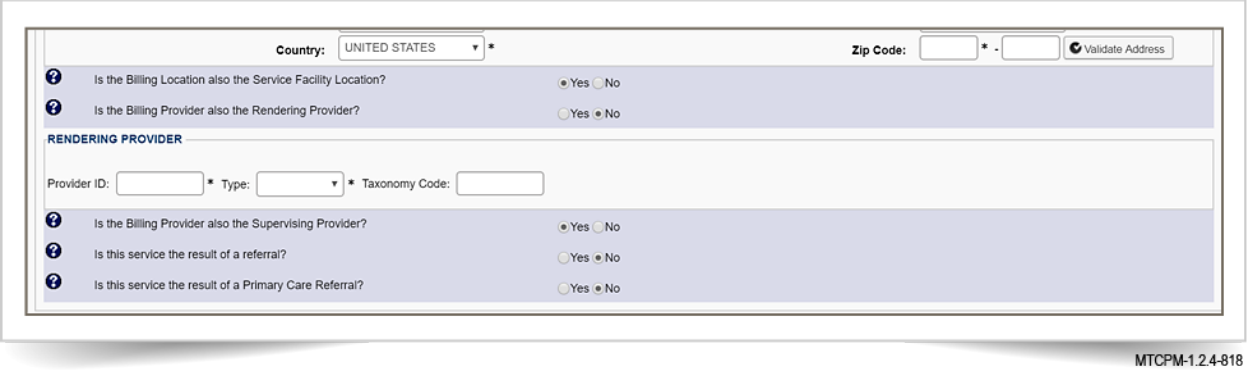


Figure 3.10.14-45. Professional Claim DDE Screen to Enter additional Provider Information. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.

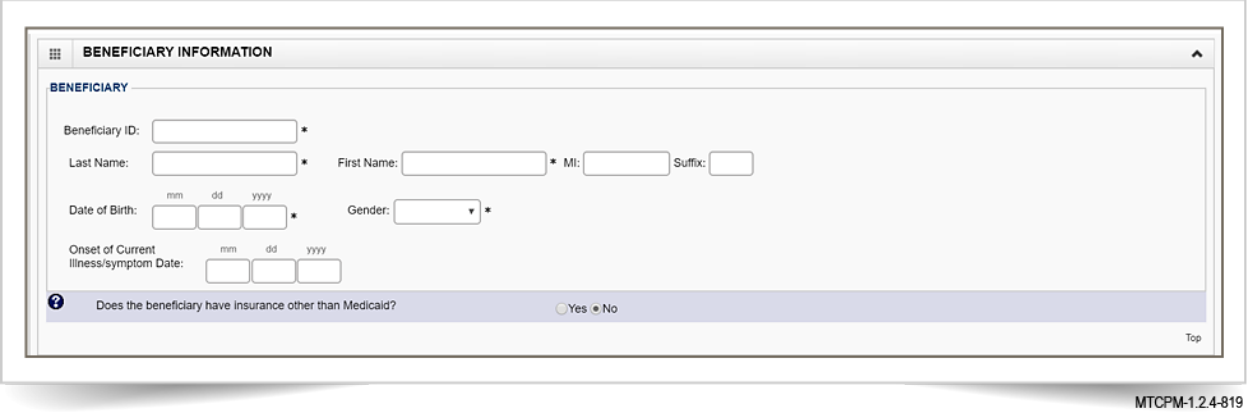


Figure 3.10.14-46. Professional Claim DDE Screen to Enter Beneficiary Information. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.

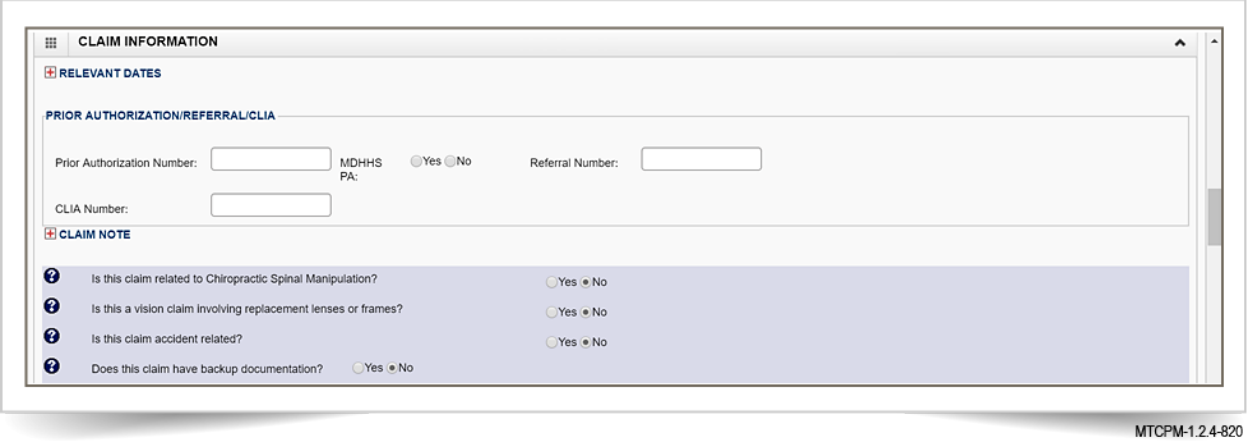


Figure 3.10.14-47. Professional Claim DDE Screen to enter Service Authorization Information. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.



Figure 3.10.14-48. Professional Claim DDE Screen to enter Claim Data. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.

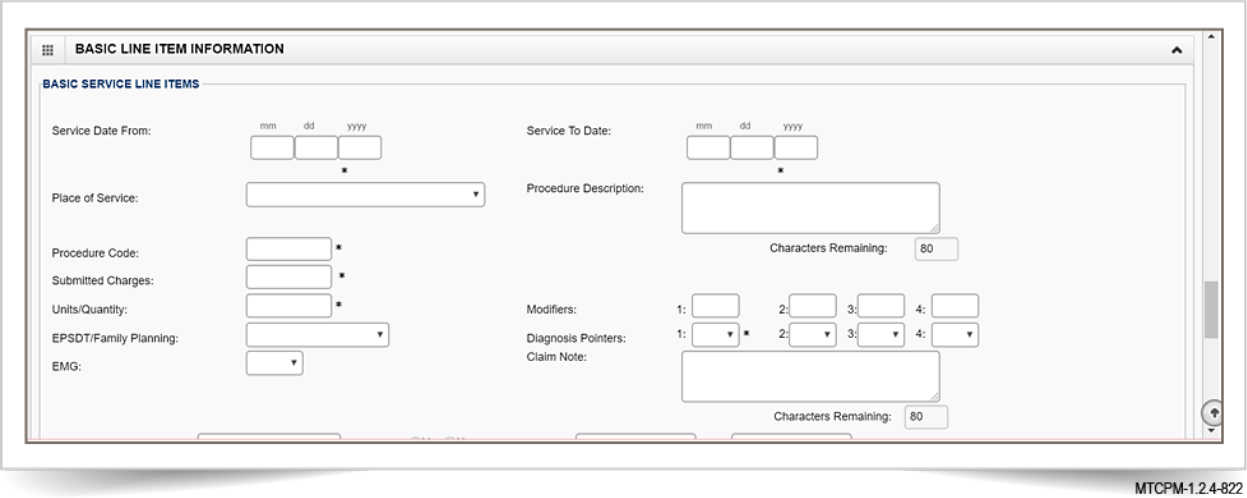


Figure 3.10.14-49. Professional Claim DDE Screen to enter Line Item. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.

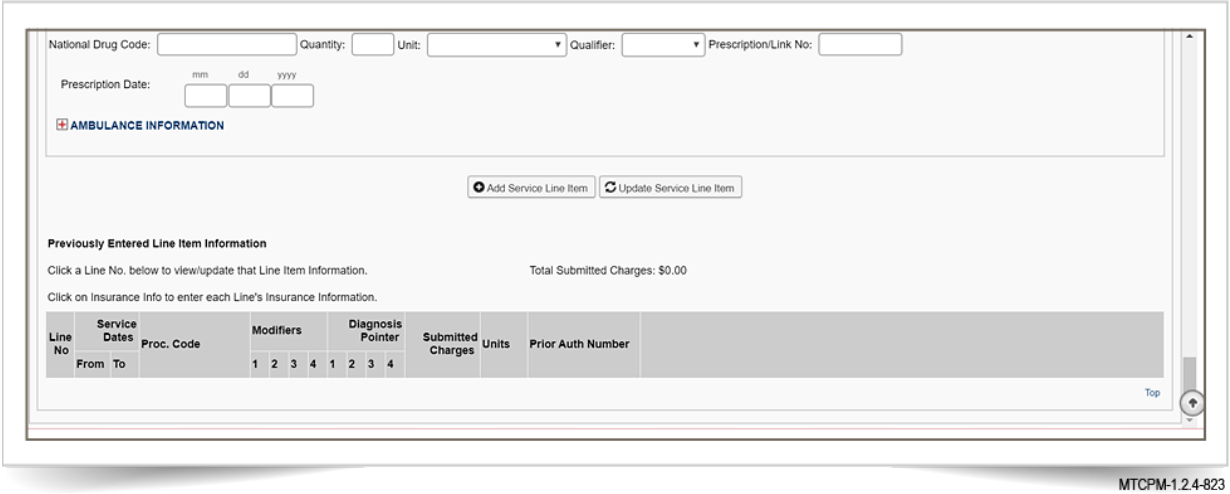


Figure 3.10.14-50. Professional Claim DDE Screen to Enter Additional Lines. Team CNSI's evoBrix X Core Claims modules supports data entry of professional, institutional, and dental claims online.

Moreover, Team CNSI's evoBrix X CPMS solution provides template driven DDE capability that is built to remove the labor-intensive task of re-entering the same data on similar claims. We provide a claim template feature enabling providers to save reusable claims data as a template. The saved claim templates can be searched, as shown Figure 3.10.14-51, using various options. Providers often have to submit very similar claims such as roster billing. The Search Template feature allows the providers to get the most appropriate template to speed up the data entry work.

Moreover, Team CNSI's evoBrix X CPMS solution provides template driven DDE capability that is built to remove the labor-intensive task of re-entering the same data on similar claims. We provide a claim template feature enabling providers to save reusable claims data as a template. The saved claim templates can be searched, as shown Figure 3.10.14-51, using various options. Providers often have to submit very similar claims such as roster billing. The Search Template feature allows the providers to get the most appropriate template to speed up the data entry work.

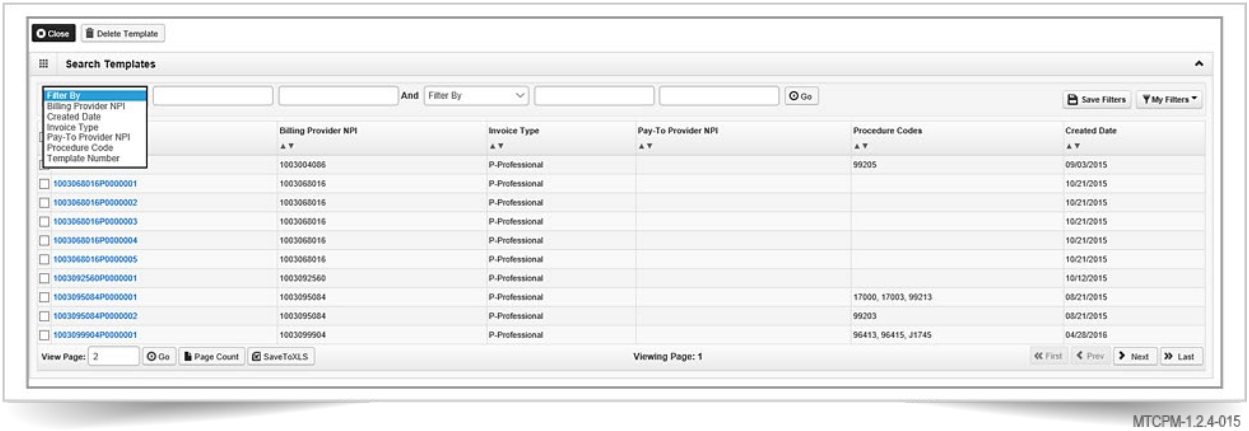


Figure 3.10.14-51. Search Templates. Saved templates help providers and Team CNSI personnel quickly select an appropriate template to enter a claim.

SAO72

The Contractor's online self-service claims entry tool shall accommodate and accept all claim types including Professional, Institutional, Dental, Encounter claims, Adjustments, Roster billing, claim corrections, and the ability to void and replace claims.

Team CNSI's evoBrix X CPMS solution provides self-service functions to authorized providers and users to enter, adjust, or void claims. The DDE functionality allows users to enter all types of claims including Professional, Institutional, Dental, Adjustments, claim corrections, and the ability to void and replace claims. Effective and timely claims processing is dependent upon accurate and reliable receipt of claims. We also understand that providers have differing needs and technical abilities. To support the full provider community, our solution provides user-friendly interfaces and supporting business operations for claims submitted on the provider portal through DDE and HIPAA 837 file uploads, batch submission through the EDI Gateway, as well as paper claims submission.

The system also allows to save a template for faster claim entry. Users can always search and use the saved templates to minimize the errors in the data entry. For business operations team the manage claims functionality provides the ability of suspended claim resolution, adjusting or voiding the paid claims, and Mass Adjustment/Resurrect/Void the paid/denied claims.

Providers can also inquire about their claims by using Inquire Claim – Provider option. In addition. providers can adjust or void their own claims by using Adjust/Void claim provider option. Users can research any claim using Inquire Claims option. Administrative options allow the authorized users to

maintain the Error Codes and RA Messages. The system also offers Gross Adjustments, Recurring Payments and Payment Withholds functionality. All these options are easily configurable as per the client's need. The solution will be customized to support roster billing claim type using self-service portal Figure 3.10.14-52 shows the claims related functions available on our web portal.

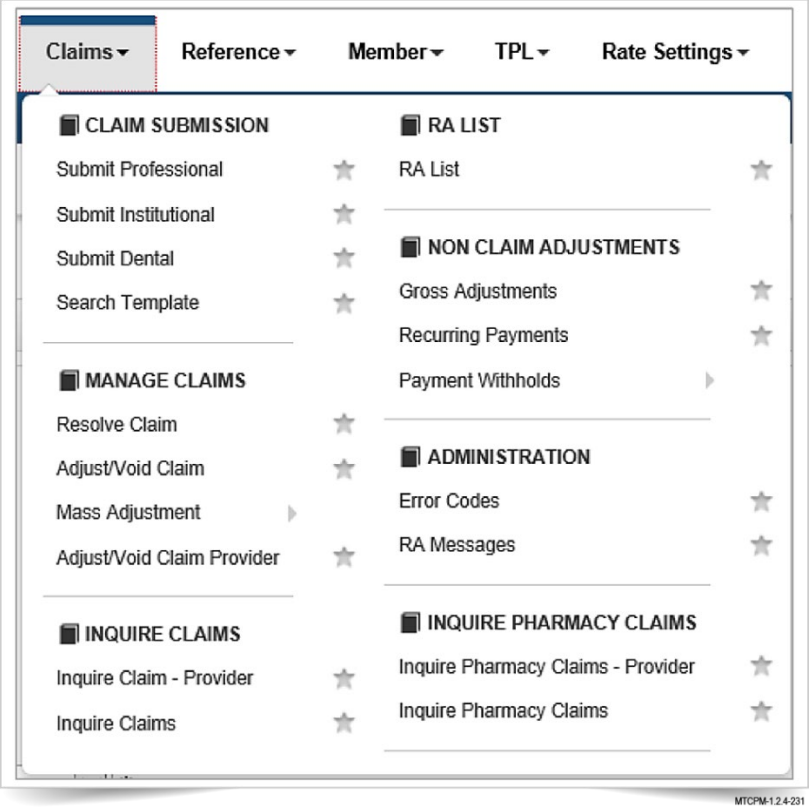


Figure 3.10.14-52. Web Portal Functions. Our solution provides powerful web-based functionality to enter, manage, and inquire claims.

SAO73

The Contractor's online self-service claims entry tool shall include a validation feature that performs real-time front end editing prior to claim submission, not allowing submission of claims that fail the front end edits. Edits will include, but are not limited to, active provider enrollment, member eligibility, valid revenue codes, procedure codes, and diagnosis codes. Front end edits(s) shall be displayed to the user for review and correction. The validation feature will not display pricing information.

The evoBrix X CPMS solution provides an online self-service claims entry tool and a validation feature that performs configurable real-time front-end editing prior to claim submission, as shown in Figure 3.10.14-53 and Figure 3.10.14-54. The evoBrix X Core Claims module offers easy to use screens directly entering professional, dental and institutional claims data into the system. It offers those providers who are authorized to do so the ability to directly key in a CMS-1500 Professional claim or a UB04 Institutional claim or an ADA Dental claim from the portal. The screens comply with HIPAA 5010 standards. The main features of the DDE include:

The main features of the DDE include:

- The data captured using the web screens is validated for provider and beneficiary enrollment
- Validation of claims data as it is entered.

- Validation for data integrity with respect to the usage of Procedure codes, Revenue codes, Diagnosis codes and HCPCS Code
- On screen error messages when error conditions are encountered, thereby giving the user an opportunity to correct the data at the point of entry to prevent incorrect data from entering the system
- Ease of claims entry due to informative messages
- Reduction in claims suspension because of immediate data validation ensuring quality claims data entering the system.

During DDE, claims undergo a series of edits for issues such as format validation and missing information checks. A system generated unique TCN is assigned to the claim and adjudicated in real-time. Immediate acknowledgment and feedback to claims submitters is a key feature of the solution. The TCN is used to track and maintain a claim in the system. It contains information to identify the media of the claim (i.e., paper, EDI, DDE), invoice type information such as professional, dental and institutional, and the date it was received.

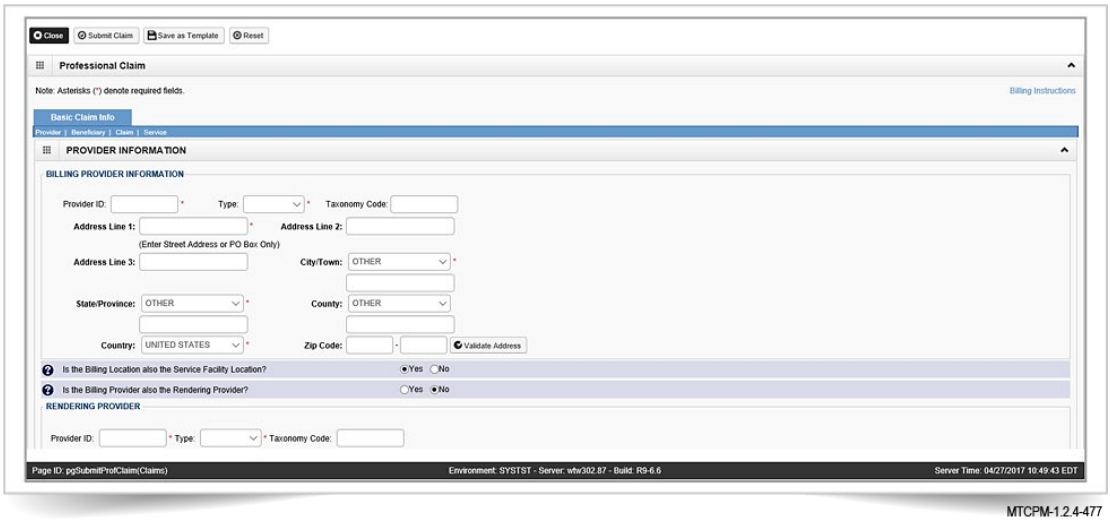


Figure 3.10.14-53. Submit Professional Claim. Our solution offers an easy-to-use screen for professional claims direct data entry.

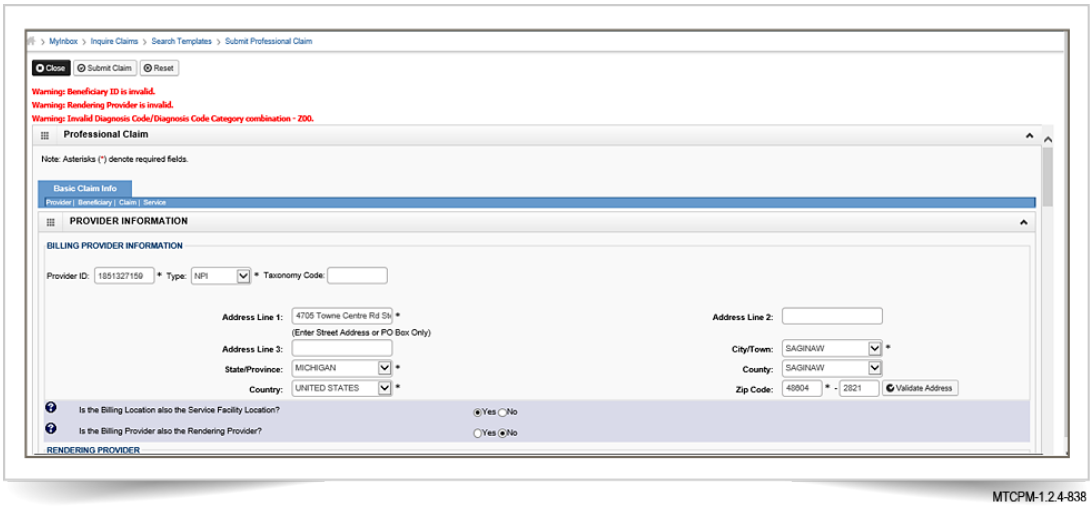


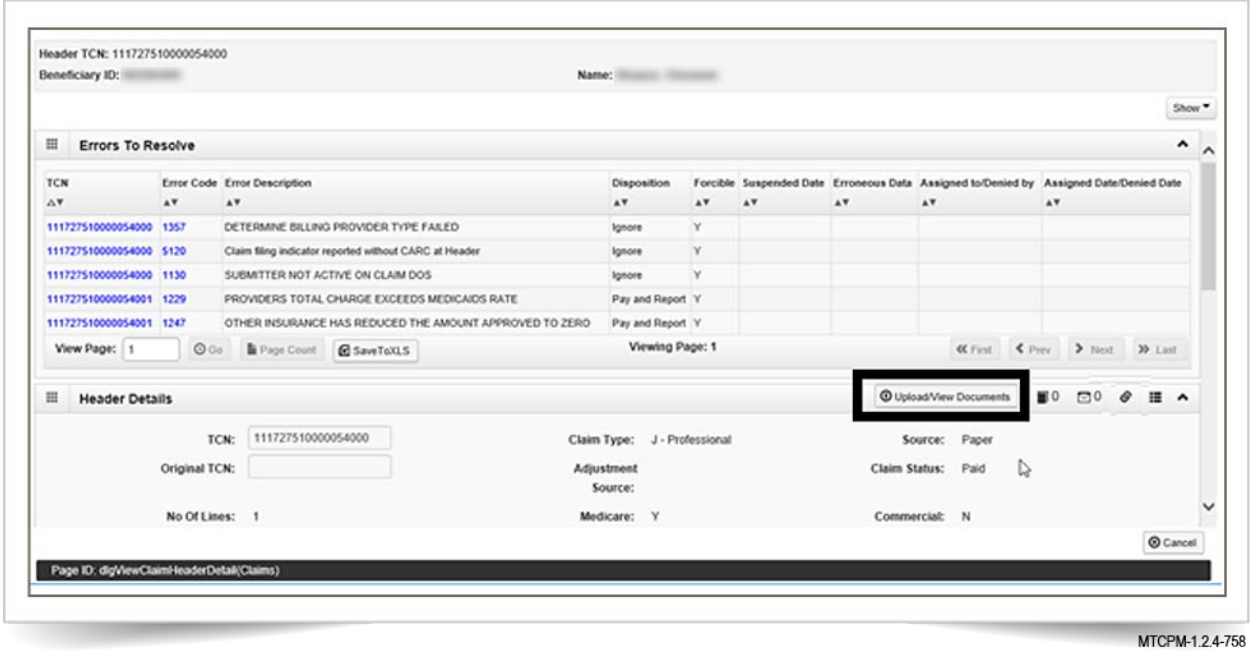
Figure 3.10.14-54. Submit Professional Claim – Data Validation. evoBrix's solution capture data using the web screens is validated for provider and beneficiary enrollment and validation for data integrity with respect to the usage of reference code sets.

SAO74

The Contractor's online self-service claims entry tool shall allow an authenticated user to upload an attachment to associate with a specific claim or multiple claims.

The evoBrix X CPMS solution includes an online self-service tool to allow an authenticated user to upload an attachment for a specific claim or multiple claims. The system provides the ability for providers, business users, DPHHS staff, to upload the supporting documents to support the claims adjudication. evoBrix X Document API Service is integrated with the claims module and the documents are stored in the ECM system with the required index parameters. Whenever an additional document is needed, the system can automatically generate a letter to provider based on the edit posted on the claim. If the attachment is not received within a pre-defined time, then the disposition of the claim is set to deny. The system is also capable to consider the existence of attachments sent by the submitter as part of a business rule. When an edit determines that the service requires additional documentation and the claim does not indicate the documentation has been received, the system automatically suspends the claim and sends an online reminder to the billing provider's inbox notifying the provider of the need for additional information to process the claim. This notice will appear the next time the provider logs into the system.

Figure 3.10.14-55 illustrates the evoBrix X Core Claims module screen which demonstrates multiple options for users to upload and associate attachments, with the use of an upload attachment functionality, authorized users can upload the documents using the web portal screens and have the flexibility to retrieve the attachment to perform their work functions.



MTCPM-1.2.4-758

Figure 3.10.14-55. Claims Screen Uploading documents and Linking Claim to an Attachment. Our solution provides multiple options for users to upload and associate attachments.

SAO75

The Contractor's online self-service claims entry tool shall instruct users to include a claim confirmation number on any paper attachment when users indicate that an attachment is being mailed or faxed in order to allow for efficient association between a claim and an attachment.

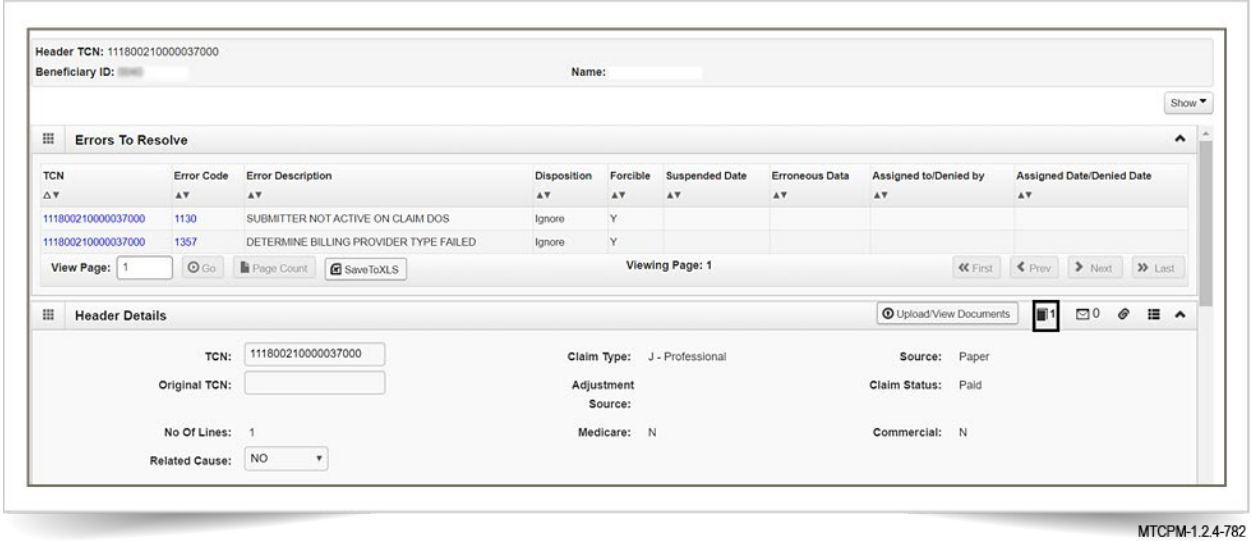
The evoBrix X CPMS solution allows providers to generate a coversheet when they decide to fax or mail a supporting document to facilitate the claims adjudication. Providers can access the claim in question through screens and generate a coversheet. The solution automatically includes all the required metadata including the TCN to the coversheet. The coversheet is mailed or faxed along with the claim attachment. The coversheet will facilitate mailroom operations to connect the supporting document to the claim based on the metadata available on the coversheet. Figure 3.10.14-56 provides an overview of Team CNSI's process for handling paper attachments.



SAO76

The Contractor's online self-service claims entry tool shall allow users to indicate paper attachments will be mailed and/or faxed.

The evoBrix X CPMS solution allows providers to generate a coversheet which includes all the required metadata information about the claim while mailing or faxing a claim attachment. The coversheet helps the mailroom operations to link that Claim attachments to a claim and also create an attachment icon (indication) on the claim whenever there is any claim attachment associated with the claim as shown in Figure 3.10.14-57.



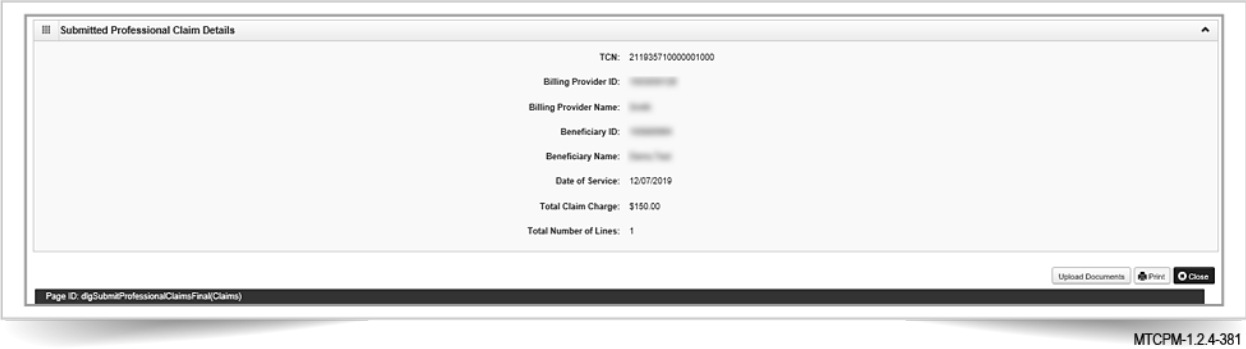
MTCPM-1.2.4-782

Figure 3.10.14-57. Claims Screen Linking Claim to an Attachment. Displaying the attachment along with claims data in the screens improves user friendliness and increases the productivity of operations.

SAO77

The Contractor's online self-service claims entry tool shall provide a tracking or control number to the user upon successful completion of the transaction.

Upon submission of the claim using the DDE option, a confirmation page will be displayed to the users indicating the successful submission of the claim. The confirmation page will include the TCN and additional details as shown in the Figure 3.10.14-58.



MTCPM-1.2.4-381

Figure 3.10.14-58. Professional Claim Submission Confirmation. Our solution generates a TCN upon claims submission.

SAO78

The Contractor's online self-service claims entry tool shall provide a configurable auto populate feature for appropriate fields for each claim type (e.g., provider information, submission date, member associated information).

The evoBrix X CPMS solution includes an online self-service tool that can auto populate feature for appropriate fields for each claim type (e.g., provider information, submission date), as shown in Figure 3.10.14-59. Based on the configuration, the system allows some of the data elements to auto populate while entering the claims. This configuration can also be controlled by the invoice type that the user is entering using the direct data entry.

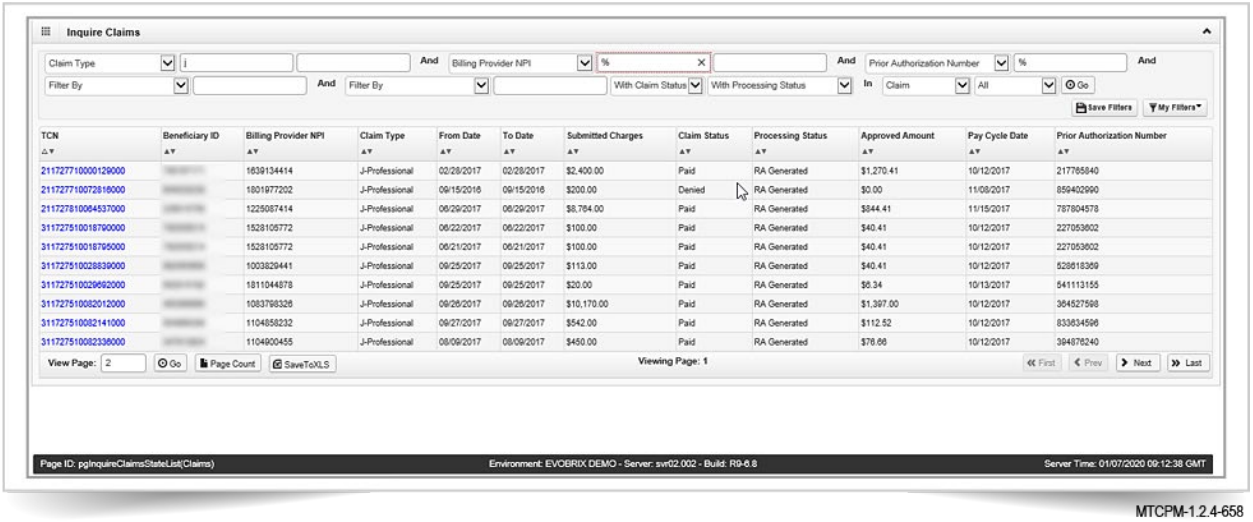
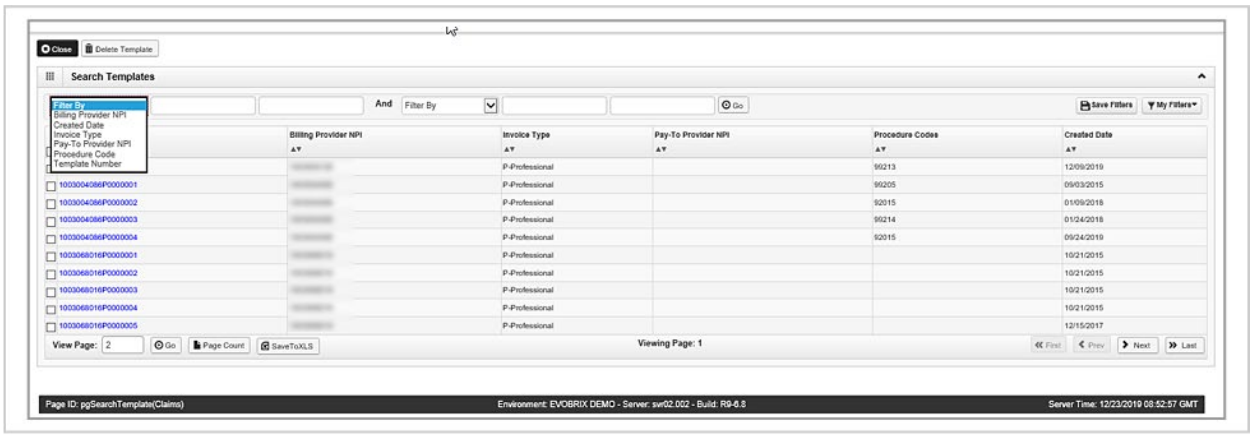


Figure 3.10.14-59. Auto populate Feature. Team CNSI's solution provides for efficient data entry with an auto populate feature for appropriate fields for each claim type.

SAO79

The Contractor's online self-service claims entry tool shall include a claim template feature that allows users to create a templates to be stored and used in the online claims entry tool.

The evoBrix X Core Claims module provides a feature which removes the labor-intensive task of re-entering same data on similar claims. The system provides the capability to save claim templates which permits the provider to reuse these to submit claims data as a template. The saved claim templates are searchable using various options, as shown in Figure 3.10.14-60. Often, a provider ends up submitting very similar claims, and the search template feature allows the provider to get the most appropriate template to speed up the data entry work.



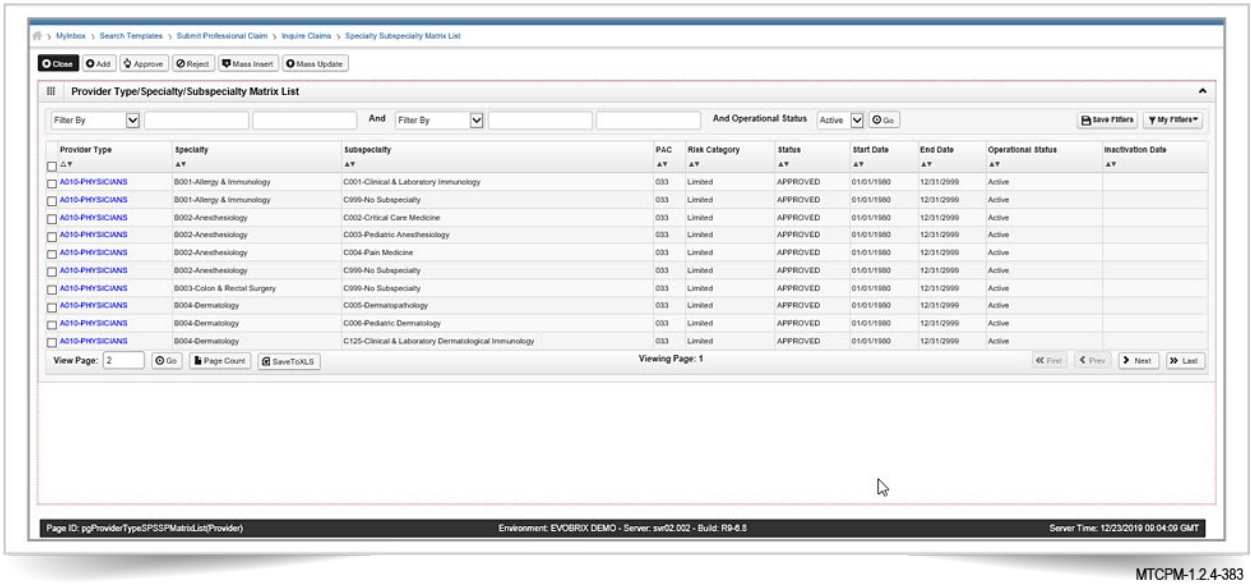
MTCPM-1.2.4-360

Figure 3.10.14-60. Search Templates. Saved templates help users quickly select an appropriate template to enter a claim.

SAO80

The Contractor's solution shall provide search capabilities for users entering data in the online claims entry tool. The search tool will include provider information and provider associated service authorization information.

The evoBrix X Core Claims module uses role-based access control to users who can access the system. Based on the associated profile that is being used to access the system the users can have access to various modules available within the system. System allows the authorized users to search for the required data like provider information, member information and authorization information required to enter the claims using the DDE functionality. Figure 3.10.14-61 and Figure 3.10.14-62 shows screens that enable users to conduct online searches.



MTCPM-1.2.4-383

Figure 3.10.14-61. Claims Inquiry Search. Our claims Inquiry screen provides search capabilities.

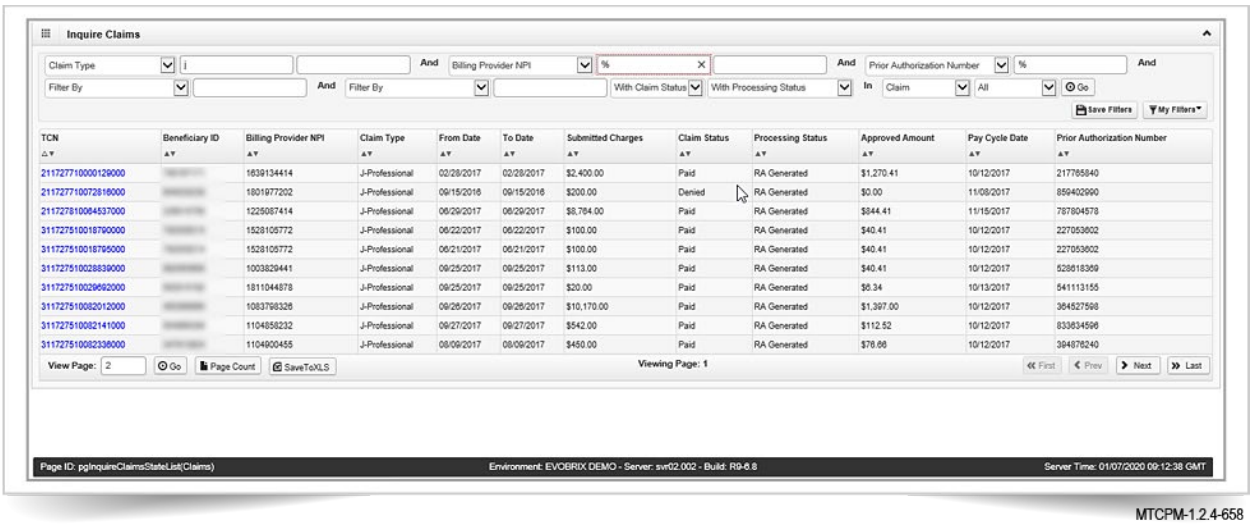


Figure 3.10.14-62. Claims Inquiry Search Results. Claims Inquiry screen provides search capabilities for provider information and provider associated service authorization information.

SAO81

The Contractor's online self-service claims entry tool shall convert all entered claims into an X12 837 format.

The evoBrix X Core Claims module provides a robust and proven method of claims intake. The system can accept the files through DDE, direct HIPAA file upload, and the EDI gateway. The online self-service tool provides the capability to accept CMS-1500 Professional claims, UB04 Institutional claims, or ADA Dental claims. The screens comply with HIPAA 5010 standards. All the submitted claims can be customized to convert into HIPAA format for further processing. The system is flexible and can be customized to convert all the claims submitted into HIPAA X12 837 format for further processing. The system uses Edifecs for all the HIPAA X12 processing.

3.10.15 Service Authorizations

This section addresses authorization requirements. The Claims Processing and Management Services solution needs to include functionality for both service authorizations and referrals. This functionality will be used by state staff, case managers, providers, and contractors. This functionality must be configurable to meet the needs of diverse programs (e.g., physical and behavioral health). Service authorizations are used to allow for specific services, track utilization, and monitor outcomes. The Claims Processing and Management solution will also create, update, and send referrals from primary care providers to other providers (e.g., specialty providers), as well as, from state staff to contractors. The Offeror must describe in detail their approach to meet each of the Service Authorization requirements in Attachment F – Requirements Response Matrix. The Offeror simply repeating the RFP requirements does not qualify as a good response as defined in Section 6.1.1 of this RFP.

Team CNSI's evoBrix X Service Authorization module enables the state to implement policies on whether medical supplies/equipment, medical test, or procedures will be reimbursed or limited to the number of service units or dollars. Team CNSI's solution is proficient in containing costs as initially designed allowing flexibility for state administrations to continue to be up to date with minimum delay on changes to medical services and treatment policy as determined by state staff or incorporating national standards. Our evoBrix X Claims Processing module currently processes approximately 80,000 prior authorizations annually in Michigan and 112,000 prior authorizations annually in Washington.

The Team CNSI Advantage

Team CNSI's in-depth understanding of business processes and technology related to Service Authorizations will result in a solution for the State that is configurable and ready to adopt to the diverse set of programs.

- Securely manage service authorizations online with evoBrix X
- Low risk implementation that is based on components that have been certified in the states of Washington and Michigan
- Efficiency with automated approvals, denials, and workflow-based routing

MTCPM-1.2.4-213

Team CNSI will implement a technical solution and operational environment that handles service authorization and referral cases in accordance with state-defined criteria and policies and approved procedures. During solution development, Team CNSI identifies all service authorization requirements and configures evoBrix X Service Authorization module to provide maximum automation of required functions. We implement state policy through rules-based, table-driven functionality, which enables us to accomplish the following tasks without the need for programming intervention, thereby increasing responsiveness to changing business needs and reducing program maintenance costs throughout the operations:

- Monitor outcomes (also discussed in our response to requirement AUTH01) of service authorizations by allowing specific services, track utilization, and monitor the status(es) (such as Approved and Rejected) at service authorization level or at service level of service authorization
- Define edits and business rules to implement service authorization adjudication processes determined for specific services
- Flag authorized services (e.g., by provider, recipient, procedure code) for prepayment review.
- Harmonizes unique program requirements within one integrated business architecture to reduce redundancy, inconsistency, and manual workload
- Fully automates service authorization processing to reduce manual workload and administrative costs and enables operational focus on quality
- Features auto-adjudication capability, improving standardization and accuracy for increased MITA alignment
- Expands reporting capabilities to enhance program performance monitoring and assessment capabilities and increase state insight into service authorization processing
- Promotes better healthcare outcomes, that ultimately lower program expenditures

- Define edit disposition codes that prevent automated adjudication of a service authorization in specific circumstances (e.g., a transaction for a recipient having third-party liability) and suspending such transactions for manual review
- Capability to track service authorization limitations and utilization by configuring limits.

A high-level summary of the evoBrix X Service Authorization solution is shown in Figure 3.10.15-1. Team CNSI's evoBrix X CPMS solution allows providers maximum flexibility to submit for processing service authorizations.



[redacted]

[redacted]



AUTH02

The Contractor's solutions shall provide the ability for authorized users (e.g., state staff, case managers, contractors) to enter, store, update, and view service authorizations.

Team CNSI's evoBrix X Service Authorization module provides the capability of entering, storing, updating and viewing service authorizations for authorized users. Figure 3.10.15-2 provides a sample screen from the evoBrix X Service Authorization module where users can enter, store, update, and view service authorizations. The solution makes use of roles and profiles to configure levels of access, such as view only, restricted control access, and full access, to authorized users. Based on the profile the user is logged in with, the system can provide control type access such that certain users can only view the service authorizations while only some users can be provided with access to store or update service authorizations.

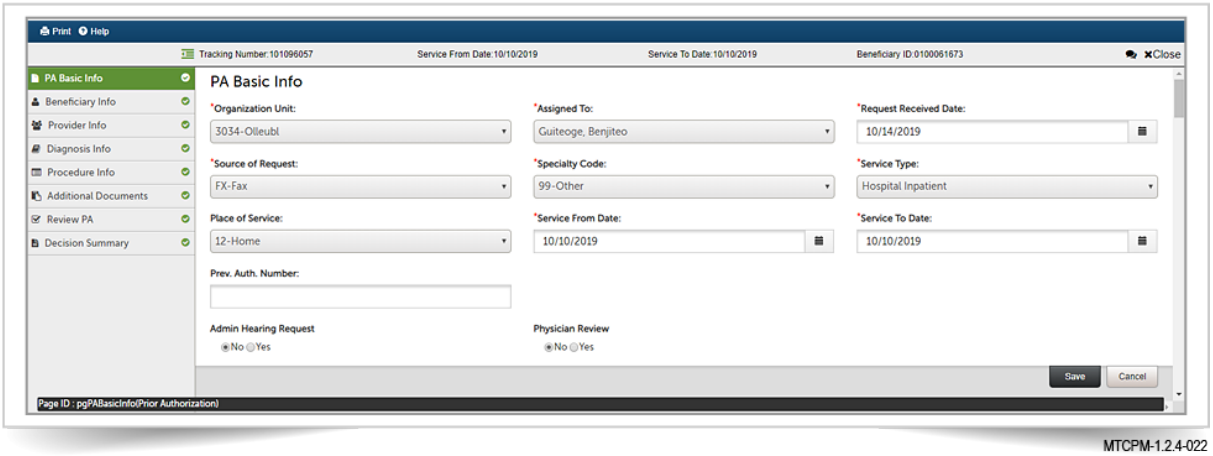


Figure 3.10.15-2. Service Authorization Information Screen. Team CNSI's solution provides the capability to enter, store, update, and view service authorizations.

AUTH03

The Contractor's solution shall track and update service authorizations based on information received from external sources (e.g., claims data, service authorization updates from UR vendor).

Team CNSI's evoBrix X Service Authorization module provides a standards-based to receive service authorization information from external sources. Our solution is fully equipped to process X12 278 transactions from any source. System leverages service authorization data to conduct relevant claims validations. For example, during claims processing, when the claims line or claims document are adjudicated, both the unit and dollar amount of the authorization is updated in real-time. The claims adjudication process may result in a draw down if the original claim is paid or an adjustment is submitted to an already submitted claim. The claims adjudication process can also void a paid claim if the service authorization decision results in in an add-back or restoration of units. The system continues to track the service authorization throughout its life cycle as shown in Figure 3.10.10-37..

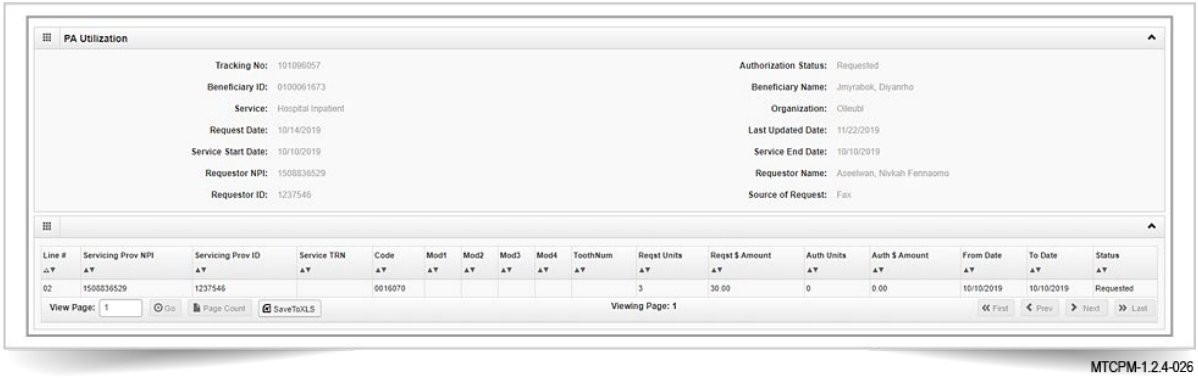


Figure 3.10.15-3. Service Authorization Tracking. Team CNSI's solution provides detailed tracking of Service Authorizations.

AUTH20

The Contractor's solution shall have the ability to receive, process, and send electronic health care service review, request for review, and response transactions required by 45 CFR Part 162, to include pharmacy drug referral certification and authorization; dental, professional and institutional referral certification and authorization (ASC X12N 278).

Team CNSI's evoBrix X Service Authorization module has the capability to receive, process, and send electronic health care service review, request for review, and response transactions (ASC X12N 278) required by 45 CFR Part 162, including:

- Institutional/Professional/Dental
- Certification/Referral

Our solution accepts HIPAA ASC X12 278 files and send the appropriate response on the Outbound HIPAA ASC X12 278 file once a service authorization determination has been made. Service authorizations for physician-administered drugs and dental services performed in a medical facility in final status may also be submitted via HIPAA ASC X12 278 transactions. An automated HIPAA ASC X12 278 response is sent to the entity submitting a HIPAA ASC X12 278 in final status provided there are no errors in the record. This response will contain the system generated service authorization number that will need to be submitted on the claim.

Team CNSI will conduct customizations to enable our solution to support pharmacy drug referral certification and authorization that is based on NCPDP Telecommunications Standard Version D.0.

AUTH04

The Contractor's solution shall include all standard X12 data elements associated with service authorization requests and responses (e.g., member, provider, code sets, dates of service).

Team CNSI's evoBrix X Service Authorization module is a web-based system that can be accessed to enter, update and adjudicate service authorization requests. Service authorization direct data entry screen uses the HIPAA 278 transaction as the base data set for the service authorizations and include all standard data elements required for the direct data entry. Team CNSI's solution processes all categories of X12 278 Request transactions including:

- Institutional/Professional/Dental
- Certification/Referral

The solution allows multiple modes for getting the authorization request into the system. It supports service types, data structures, and information necessary to process HIPAA 278 online and batch transactions. The solution service authorization module supports program-based screens that support the differing data requirements. The solution ensures that all the X12 data elements associated with service authorization requests and responses are loaded and processed, and appropriate outbound transactions are generated. Team CNSI ensures that no information submitted in X12 transactions is dropped by storing all the elements, even if it is not currently used by MPATH. Our solution accomplishes this by storing the information as either a processing or situational data element.

Service authorization can have multiple service lines, different servicing providers and provider types. Each service line identifies the servicing provider rendering the service at the detail service line level. Our solution allows an unlimited number of service lines along with the procedure codes and dates per line to be added to a prior authorization request. Each service line can have up to four modifiers per service code with "from" and "to" dates of service.

Once a service authorization request has been initiated, requests are validated to verify compliance with HIPAA 278 transaction data requirements while the authorization data is entered online. Field level edits and business rules are then applied (e.g., valid member identifier, servicing provider eligibility.) to ensure that all online prior authorization request data submitted is complete and valid before the system accepts the request. Once complete data is entered, the request is accepted into the system and a unique non-duplicated system generated service number (this number is used to associate all later submissions to the original request) is auto-assigned.

AUTH05

The Contractor's solution shall have the capability to receive and or enter a retroactive service authorization(s) based on configurable business rules.

Team CNSI's evoBrix X Service Authorization module will be customized to support retroactive service authorizations. Once the retroactive service authorization is rejected or approved, the system identifies all the paid claims that are related to the service authorization. The claims are processed through the adjudication cycle again based on the decision made on the service authorization and will be adjusted or voided accordingly.

AUTH07

The Contractor's solution shall include processing logic when creating or updating service authorizations (e.g., procedure code not appropriate for gender of member, procedure cannot be billed by the provider type, duplicate service authorization request, invalid data) and route exceptions to the appropriate work queue.

Team CNSI's evoBrix X Service Authorization module includes processing logic when creating or updating service authorization. Processing logic is implemented in our evoBrix X RuleIT engine and every service authorization will be validated, and the appropriate edits will be posted if the service authorization fails the validation. DPHHS will have the ability to further review the service authorization request and act accordingly. Additional rules will be configured according to DHPPS needs. Our solution includes workflow capabilities based on the service types associated by the user who is eligible to work on service authorizations. Workflow management processes will be configured to support routing service authorization exceptions to the appropriate work queue depending on the service types and number of authorizations that a user can work. Team CNSI's integrated workflow management solution supports the State's goals of improved automation, reduced manual intervention, configurable work routing, and task management across different business processes. The evoBrix X delivers a proven workflow solution with table-driven configurable rules, task routing, assignment, and tracking capabilities. With these features, the system handles all aspects of workflow access, assignments, and execution of business processes, such as service authorization requests and service authorization mass updates. These settings are configurable through the work management administration screens. Service authorization organization units and service types can be configured to route the exceptions to the departments that specialized in that area. In addition, we have the capability to allow a user to either self-assign the newly submitted authorizations or to assign authorizations to others from the queue/work list.

AUTH08

The Contractor's solution shall provide the capability to automatically authorize services by various configurable data elements (e.g., procedure codes, diagnosis codes, provider types, date ranges, dollar amounts, units).

Team CNSI's evoBrix X Service Authorization module will be customized to provide the capability to automatically authorize services based on configurable data elements such as procedure codes, diagnosis

codes, provider types, data ranges, dollar amounts, and dollar units. Our solution will facilitate an auto-approval process, which allows for quicker turnaround of the decision and adjudication of an authorization. The auto approval process is supported by business rules captured in the rule's engine, evoBrix X RuleIT, by leveraging RuleIT business services used by claims processing and other functionality, including provider functions. For example, the prior authorization approval process uses the same service to verify provider credentials. Similarly, the prior authorization approval process uses the provider service matrix service used by claims processing to validate the ability of the provider to perform a service. The implementation of these services makes the auto approval process feasible, expedient and ensures consistency of the validation within the system.

AUTH09

The Contractor's solution shall have the ability to capture and maintain the requested service authorization details (e.g., units, dollars, begin and end dates) and the approved authorization details (e.g., units, dollars, begin and end dates) on the authorization record and notify (e.g., web portal, fax, phone, letters, X12 278) the requestor of the decision.

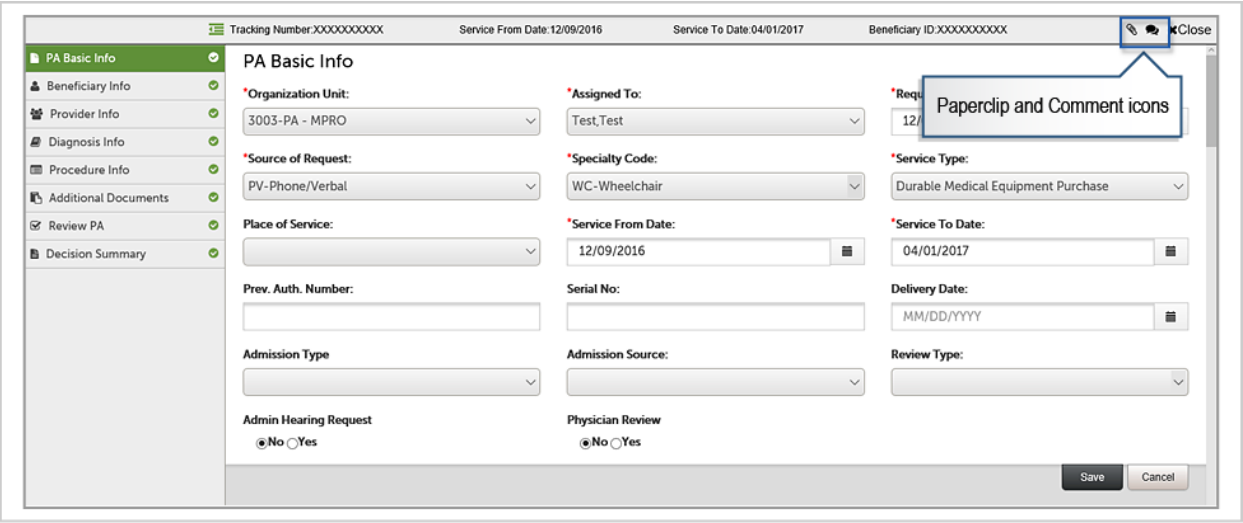
Team CNSI's evoBrix X Service Authorization module provide the ability to capture and maintain service authorization request and approval details as a part of the authorization record. Figure 3.10.15-4 provide a description of web page demonstrating service authorization information. Team CNSI's solution tracks service authorization service limitations and utilization by configuring limits. Limits are established to cover various periods, service categories, including lifetime, year, month, or state fiscal year. The entire configuration process is conducted through the administration screens. The limit type can be units or dollars and if a member utilizes all units or dollars defined for the service, the claim adjudication process posts the edit. Service authorization start and end dates are also captured.

Team CNSI's solution provides the capability to send notifications by web portal, fax, phone, letters, and X12 278. Team CNSI will configure notification letter templates during implementation and, with DPHHS approval, will load the templates into the system. Our solution is integrated with the Pitney Bowes Doc 1 Suite to generate correspondence notices and supports both on demand and auto generation based on pre-configured schedule. Once the template has been approved, it will be available when generating any correspondence for a given service authorization tracking number. DPHHS staff with the appropriate credentials can add, modify, and delete letter templates and content. For service authorizations which are auto approved, the approval letter will be generated automatically and sent to the requesting provider. The notification may be sent to the provider by mail or secure website and to the member by mail.

The system provides capability to choose whether a letter will be sent only to the provider or to both the provider and member. Members typically receive notification only in the case of a denial. Upon generation of the letter, the system retrieves the information already stored from the service authorization record to use to input information into the template. Templates are used to ensure consistency in the content as the text of the letter is fixed and only data which is associated with the specific service authorization (such as member, name, provider, addresses, and service authorization number) need to be added by the systems. The user reviews the data and can correct or input additional information for that individual service authorization. All correspondence generated for the given service authorization is archived in FileNet.

Notification letters generated through the system will contain the required provider and member details along with the decision made on the services requested in the service authorization. When a service authorization request has been approved, the letters generated will contain details on each service line along with the authorized units and amount for each service line. Providers can view these details through a secure portal, if the provider is mentioned as either the requesting or servicing provider on the service authorization request.

An electronic copy for every notification letter (or other correspondence) that has been generated for a given service authorization tracking number is saved and archived in FileNet. Authorized DPHHS users are given access to view service authorizations, attachments to a service authorization, and associated correspondence are as shown in Figure 3.10.15-4. PAs submitted via the provider portal which are auto approved will provide approval thru the provider portal.



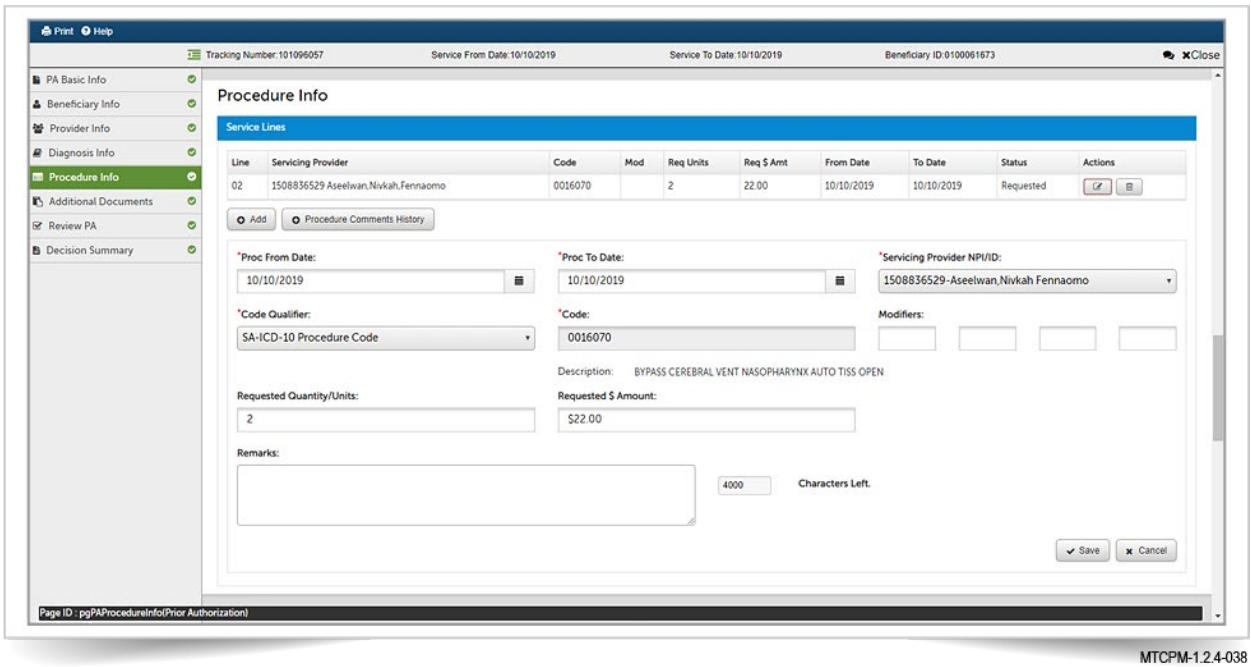
MTCPM-1.2.4-225

Figure 3.10.15-4. Service Authorization Details. Team CNSI's solution maintains detailed record of service authorization requests and approvals and maintains a history of communications.

AUTH10

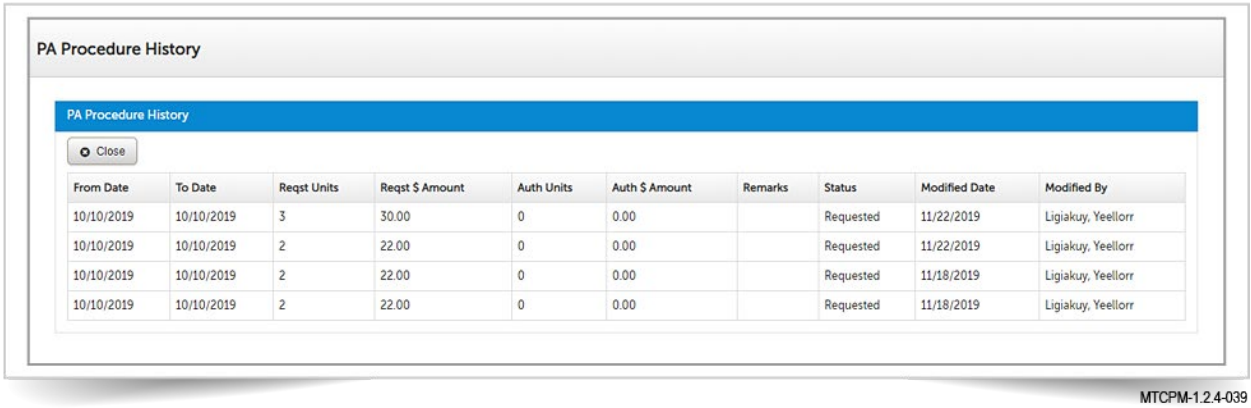
The Contractor's solution shall provide the ability to update service authorizations (e.g., extend or limit effective dates, update authorized limits) based on configurable business rules while maintaining a history of the changes to the record.

Team CNSI's evoBrix X Service Authorization module provides the ability to update service authorizations based on configured business rule while maintaining a history of changes to the record. During the review of service authorization, a service authorization reviewer may modify fields on a submitted request as shown in Figure 3.10.15-5. The system will notify the user with one or more appropriate validation messages during this process. Fields such as authorized units, amount, and service dates are updated based on configured business rules through evaluation of the service lines submitted. The reviewer has the ability to approve all service lines or make decisions on independent service lines in the request. The system maintains a log of all field changes. This supports an audit of PA history if one is needed. When the final determination is made, including entry of the determination rationale, the system records the information with the reviewer's name and date-stamp and enabling audit review. The user also can view historical changes of a service authorization as shown in Figure 3.10.15-6.



MTCPM-1.2.4-038

Figure 3.10.15-5. Updating Service Authorizations Online. Team CNSI's solution has configurable rules to update service authorization data elements based on changes to the record.



MTCPM-1.2.4-039

Figure 3.10.15-6. Service Authorization History. A detailed history of all changes to a service authorization is maintained by our solution.

AUTH11

The Contractor's solution shall have the ability to automatically generate approval and denial notices/communication to requesting and assigned providers, case managers, and members based on their communication preference for service authorizations based on configurable business rules.

Team CNSI's evoBrix X Service Authorization module provides capabilities to support service authorization end-to-end processes. New service authorization requests are routed to the appropriate DPHHS defined review staff based on configurable rules. Service authorization requests are presented to the assigned review staff online for processing. Once the service authorization has navigated through the service authorization workflow a Final Service Authorization Review Page is available to review the decision summary. Our solution provides the ability to automatically generate approval and denial notification letters to the requesting and assigned providers, case managers, and members for service authorizations based on the configured business rules. The service authorization process, shown in Figure 3.10.15-7, will be configured to accommodate automatic generation of approval and denial

communication based on the communication preferences other than letters. The system will provide a single unified location for providers to view related service authorizations issued to them. Our solution will be configured to generate confirmation correspondence using our correspondence framework to generate communications based on the service authorization status.

Notification letters generated through our solution will contain the required provider and member details, along with the decision made on the services requested in the service authorization. When a service authorization request has been approved, the letters generated will contain details on each service line along with the authorized units and amount for each service line.



AUTH12

The Contractor's solution shall allow for flexible and configurable service authorizations (e.g., required fields, edits, service authorization types, business rules) to support a variety of programs, benefit plans, and claim types. The solution shall assign a unique number to service authorizations.

As described in Figure 3.10.15- and Figure 3.10.15-7, Team CNSI's evoBrix X Service Authorization module provides a flexible and configurable service authorizations capability to support a variety of programs, benefit plans, and claim types. The system implements auto-approval of service authorization submissions by executing business rules written in evoBrix X Rules Engine (RuleIT) during the decision-

making process. The system further uses an integrated approach with other business areas such as provider, member, and claims by not only providing access to these subsystems from online web screens, but also by reusing business service such as validation of provider eligibility to perform a service, validation of member eligibility to avail the requested service. The rules engine framework implements the service authorization decision-making process. Team CNSI's solution retains the service authorization number from any source system and has the capability to create and assign a unique service authorization number for tracking purposes.

AUTH15

The Contractor's solution shall have the capability to perform mass updates to service authorization records (e.g., change a provider ID number, procedure code) with pending or approved but unutilized services that may initiate workflow for updates that require review and approval.

Team CNSI's evoBrix X Service Authorization module currently does not have the capability to perform mass updates to service authorization records with pending or approved but utilizes a service that may initiate workflow for updates that require review and approval.

Our solution can be customized to perform mass updates to service authorization records by state worker in response to receipt of reference code updates from state approved sources on the update of codes such as procedure codes, diagnosis code as well as other on other service authorization records data elements such as provider ID number. Solution follows the workflow process for mass updates that require review and approval. The mass update requestor will manually fill the required details and sends a request through an online notification to a mass update approver to approve the mass updates. Once the mass update approver approves the mass update request, the solution sends the notification back to state worker/mass update requestor and sets the mass update overnight batch process. Once the overnight batch process gets completed successfully or fails, mass update requestor will receive the notification accordingly. Team CNSI will add the capability to perform mass updates leveraging our experience and capability in other areas of our solution. Users will be able to view the referral listing and select one or more records for updates. Examples of mass update changes include changes to a provider ID number and procedure codes.

AUTH16

The Contractor's solution shall have the capability to put requested service authorizations in a pending status if any information is invalid, missing or needs to be approved by another entity based on configurable business rules.

Team CNSI's evoBrix X Service Authorization module has the capability to put requested service authorizations in a pending status. The service authorization request is placed in pending status while waiting for the additional information. If the additional information is not received within the requested timeframe (established based on the turnaround time associated with the service authorizations service type), the request is denied and the decision/reason stating missing documentation. All interactions and documentation relating to the request for additional information are recorded and retained in the service authorization file for reference, if needed, to support hearings and appeals.

AUTH01

The Contractor's solution shall have the ability to track services received against services approved based on service authorizations and/or claims.

Team CNSI's evoBrix X Service Authorization module can track services received against services approved based on a specific service authorization and/or claim. The capability can be addressed in two

different ways in the evoBrix X CPMS solution: (1) from the Service Authorizations area or (2) from the Claims area. The combination of these approaches enables the DPHHS to monitor outcomes for services rendered.

From Service Authorizations area, the user can track services as follows:

1. Click on an individual item in the "Tracking No." hyperlink on service authorization request list screen, as shown in Figure 3.10.15-8.
2. The system opens a service authorization detail screen, also shown in Figure 3.10.15-77, where the user is presented the decision summary section to track services received against services approved on a service authorization.

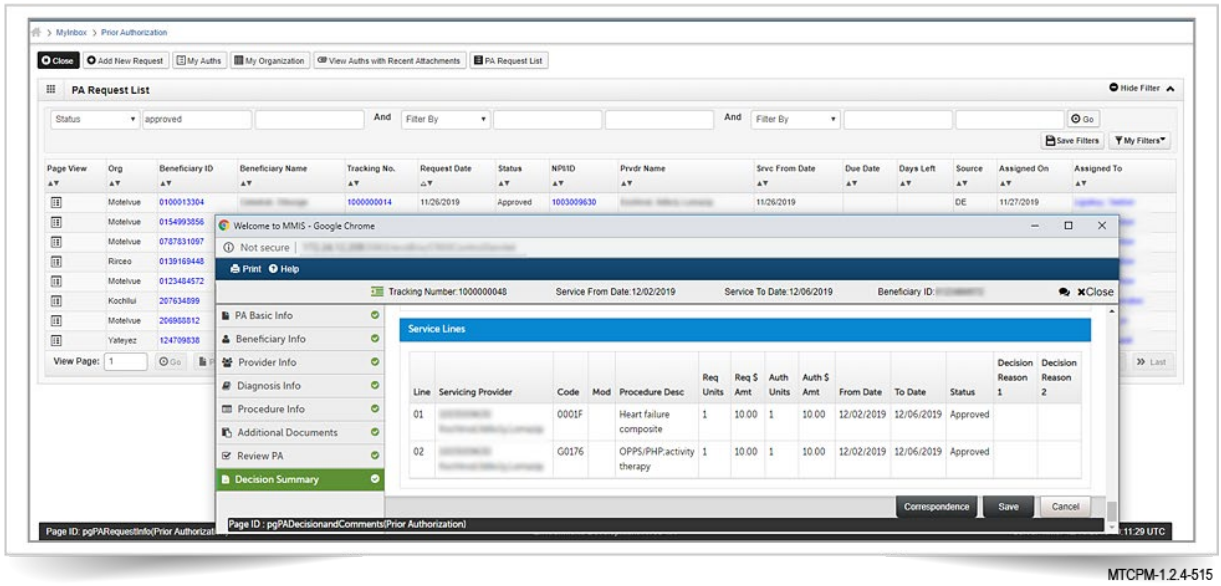


Figure 3.10.15-8. Viewing and Tracking Services Approved for a Service Authorization. Team CNSI's solution provides a robust tracking capability to monitor services approved on a service authorization.

3. Alternatively, the user has the ability to click on "Page View" icon on service authorization request list screen to view the service authorization utilization, where user can track services received against services approved on a service authorization. The Service Authorization Utilization view is shown in Figure 3.10.15-9.

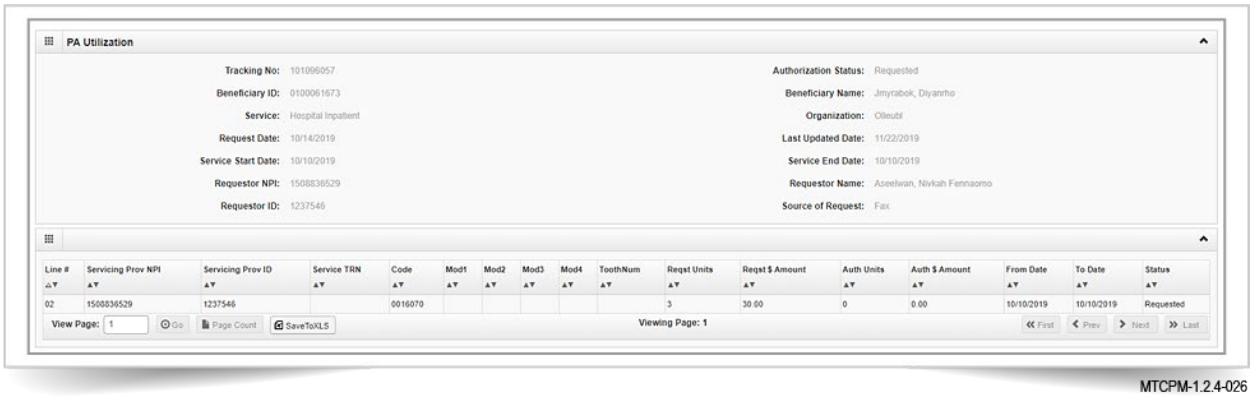


Figure 3.10.15-9. Service Authorization Tracking. Team CNSI's solution provides detailed tracking of Service Authorizations.

From Claims area, a user has the ability to track services received against services approved by:

1. Filter the listing of claims using the Service Authorization Tracking Number in Inquire Claims screen.
2. Click on TCN hyperlink to navigate to Claim Header or Line Detail screen.
3. These screens present an "Auth #" hyperlink along with value in the text field in Header Details or Line Details section.
4. The system presents the Service Authorization Utilization screen showing the service authorization details used for adjudication by the claim. Figure 3.10.15-10 presents the results of these actions to view services rendered via claims area of our solution.

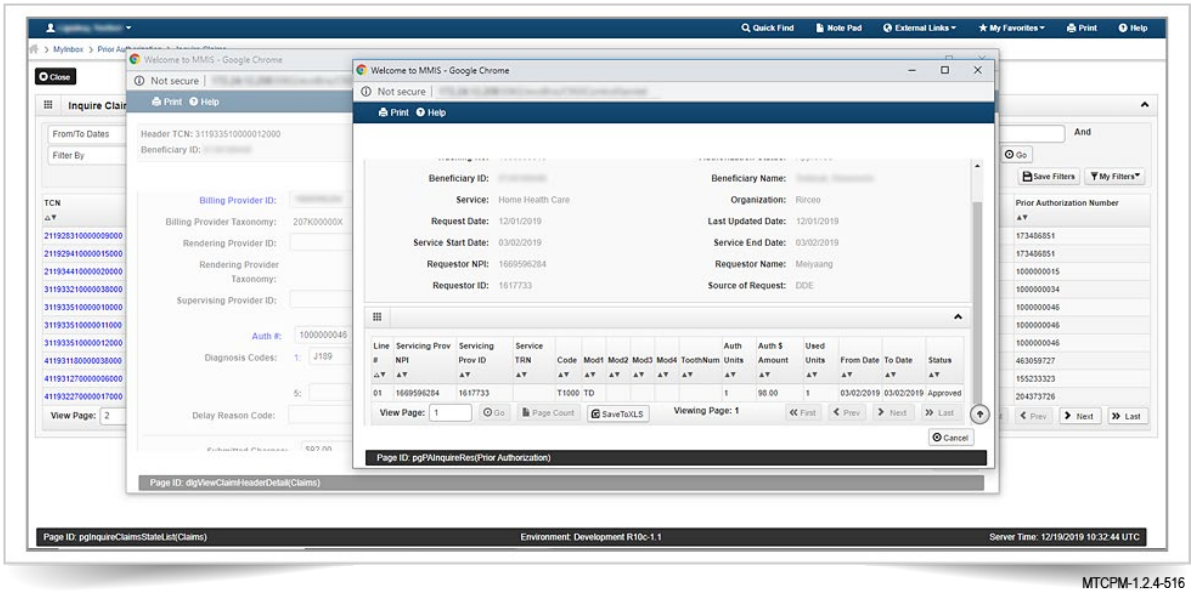
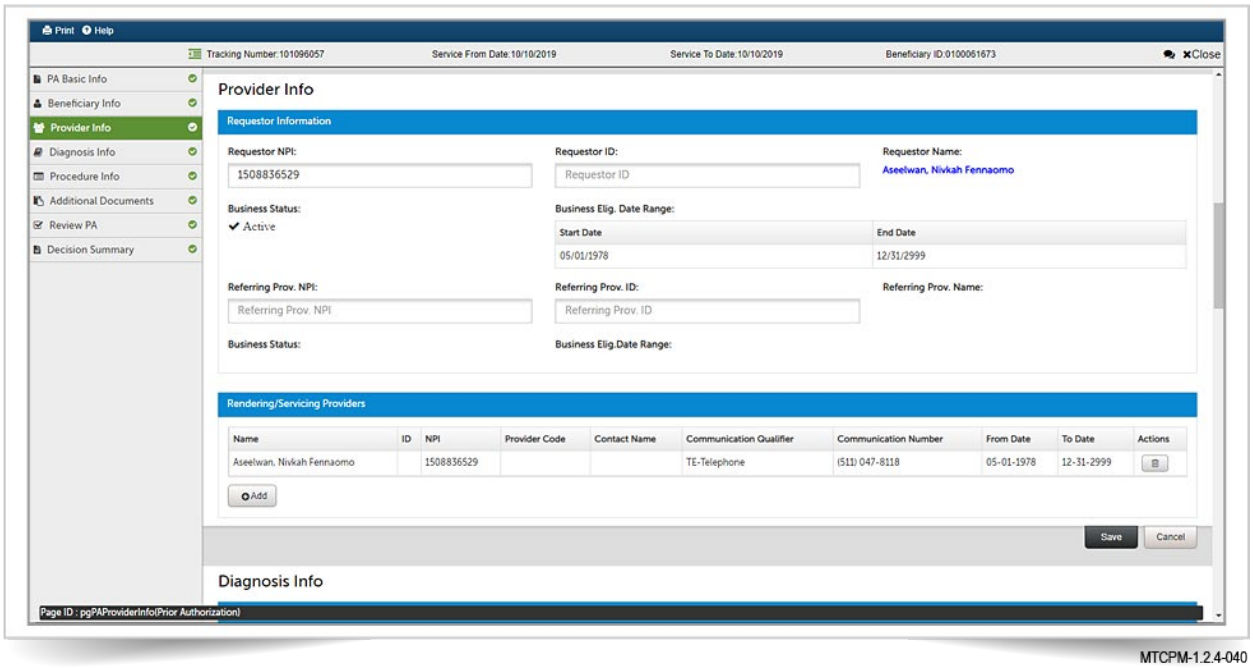


Figure 3.10.15-10. Tracking of Services for Approved Service Authorizations via Claims. Services approved via service authorizations and paid by claims may be viewed from the claims area of our solution.

AUTH06

The Contractor's solution shall include configurable referral functionality to include creating, updating and sending referrals from primary care providers to other providers (e.g., specialty providers) to allow for claims payment. The solution shall assign a unique number for each referral.

Team CNSI's evoBrix X Service Authorization module enables for configurable referral management from primary care providers to other providers as demonstrated in Figure 3.10.15-11. The solution provide the ability to capture the referring providers NPI along with the requesting providers NPI, if a referral is required for the services rendered. The provider can also submit the referring providers NPI on the claims. The solution facilitates logical linking of multiple referrals by allowing the provider to filter by the referring providers NPI on the claim inquiry screens. The solution has several edits implemented which are associated with eligibility, valid values, duplicate checks and service code limits. Team CNSI's solution does have the capability to assign a unique number for each referring provider that exists in the system. Team CNSI will work with DPHHS to configure these rules to meet the criteria for general and specialty referrals.



MTCPM-1.2.4-040

Figure 3.10.15-11. Referrals in Team CNSI's evoBrix X Service Authorization. Team CNSI's solution provides the capability to create, update, and send referrals.

AUTH13

The Contractor's solution shall have the capability to filter and view service authorizations (service authorization detail list) based on configurable filters (e.g., provider, procedure code, diagnosis code) and allow mass updates from the service authorization detail list.

Team CNSI's evoBrix X Service Authorization module has the capability to filter and view service authorizations based on configurable filters. In fact, the entire system provides access to views called List Pages that enable users to view a listing of records. The service authorization module provides a list page to view and filter service authorization data, as shown in Figure 3.10.10-36.. Team CNSI's solution enables the following data elements when creating filters on the Service Authorization Request List screen:

- Assigned On
- Assigned To
- Beneficiary ID
- Beneficiary Name
- Days Left
- Due Date
- NPI/ID
- Org
- Procedure Code
- Provider Name
- Request Date
- Source
- Specialty Code
- Service From Date
- Status
- Tracking No.

Additional data elements may be added through configuration as required by DPHHS.

Our solution can be customized to allow mass updates from the service authorization detail list. Mass update requestor can navigate to the appropriate mass updates screen where they can fill out the required details on which mass updates should occur and send a request through an online notification to a mass update approver to approve the mass updates. Team CNSI provides mass update capabilities in other areas of our solution such as claims and provider rate management. We will leverage this capability and customize the service authorization list page to support mass updates of Service Authorizations. This capability will enable users to make changes such as code updates across one or more selected service authorizations.

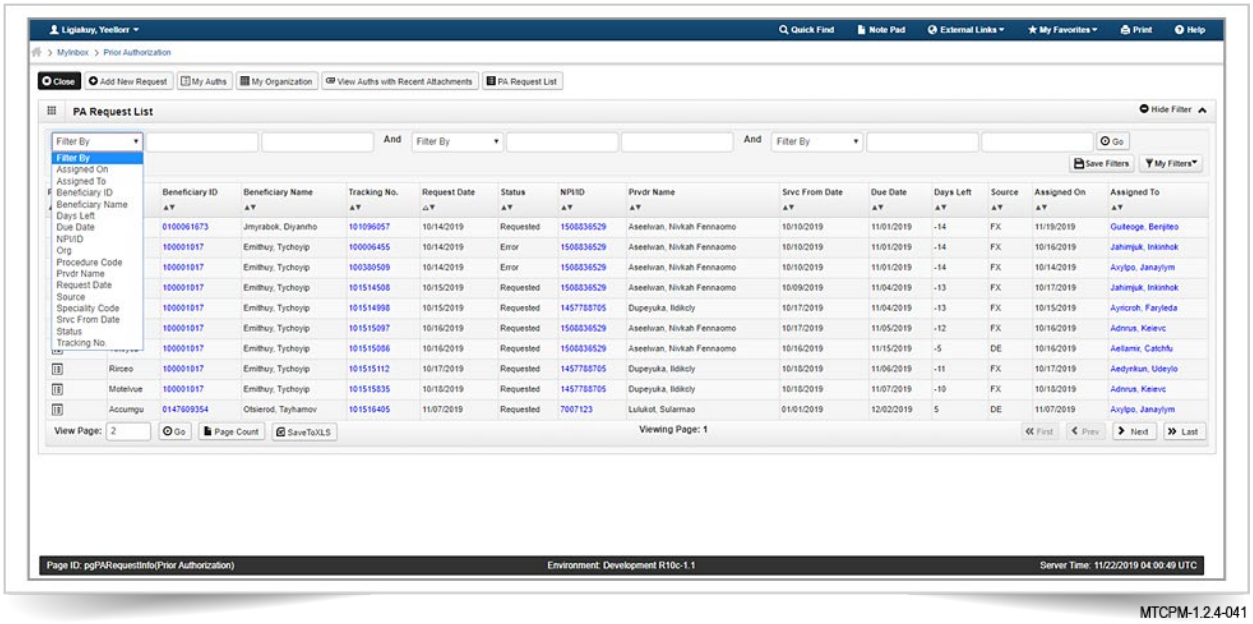


Figure 3.10.15-12. Service Authorization List Page. Our service authorization list page provides the capability to filter the listing using a variety of field combinations.

AUTH14

The Contractor's solution shall have the capability to perform mass updates of referrals (e.g., member changes PCP, PCP who are retiring, service code changes) that may initiate workflow for updates that require review and approval.

Team CNSI's evoBrix X Service Authorization module currently does not have the capability to perform mass updates of referrals that may initiate workflow for updates that require review and approval. Team CNSI will leverage existing mass update processes in other areas of our solution to provide the capability to perform mass updates of referrals. Users will be able to view the referral listing and select one or more records for updates. Examples of mass update changes include member changes PCP, PCP who are retiring and service code changes.

AUTH18

The Contractor's solution shall have the capability for authorized users to send requests via workflow or their preferred method of communication (e.g., inbox, fax, mail) for additional information related to service authorization requests.

Team CNSI's evoBrix X Service Authorization module generates notices for denied, approved, and pending (requesting for additional information) authorizations. If additional documentation is required, the user has the ability to send a request via our built-in service authorization workflow (i.e., electronically, telephonically, fax, or hard copy) to the requesting provider delineating the additional information related to service authorization requests that is required to make a decision. Notices are predefined in a format that is filled with appropriate information (e.g., authorization identifier, service information, decision reasons, provider information and client information). Authorized users have the ability to re-generate the notice. Figure 3.10.15-13 presents how the user selects generation of correspondence when requesting additional information related to a service authorization.

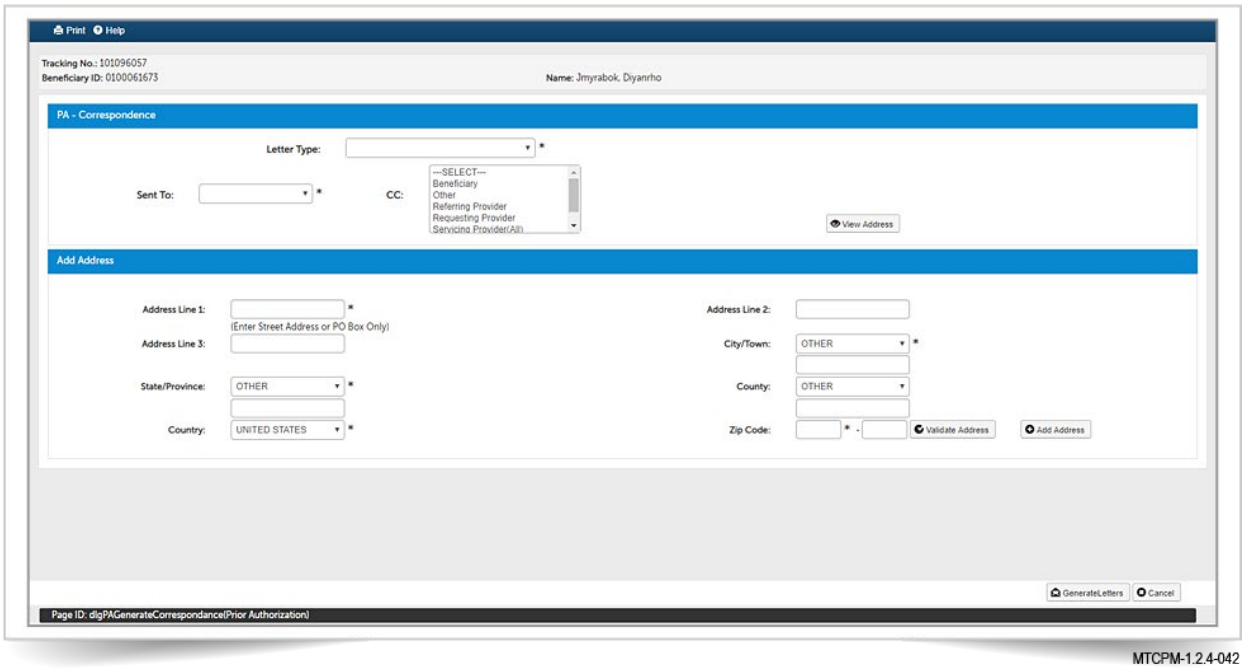


Figure 3.10.15-13. Service Authorization Additional Information Request via Correspondence. Our integrated Pitney Bowes correspondence generation framework provides a powerful option for requesting additional information and maintain a complete history of communications for service authorizations.

AUTH22

The Contractor's solution shall provide the ability to allow approved services (e.g. private duty nursing) on one service authorization to be used by multiple providers during overlapping dates of service based on configurable business rules.

Team CNSI's evoBrix X Service Authorization module provides the ability of using the same or different services by multiple providers during dates of service within same service authorization, when separate service lines are created on the service authorization associating each to a different provider for overlapping dates of service and approve the service lines. Service Authorization with one or more service lines can be associated to one or more claims.

AUTH23

The Contractor's solution shall provide and maintain the capability to create, edit and void services authorized and to extend or limit the effective dates of the authorization. The solution shall maintain the original and the change data in the service authorization record.

Team CNSI's evoBrix X Service Authorization module provides the capability to create, edit, and void services authorized and to extend or limit the effective dates of the authorization as shown in Figure 3.10.15-14. Both the original and the change data in the service authorization record is maintained for historical, auditing purposes. The solution provides online access to providers and authorized users via a user-friendly business process wizard to provide key information required for processing of a prior authorization request. Our solution currently supports service types, data structures and information necessary to process HIPAA 278 online and batch transactions. The system supports program-based screens that support the differing data requirements. Authorization can have multiple service lines having different servicing providers and provider types. Each service line identifies the servicing provider rendering the service at the detail service line level. System allows unlimited number of service lines along with the procedure codes and dates per line to be added to a prior authorization request.

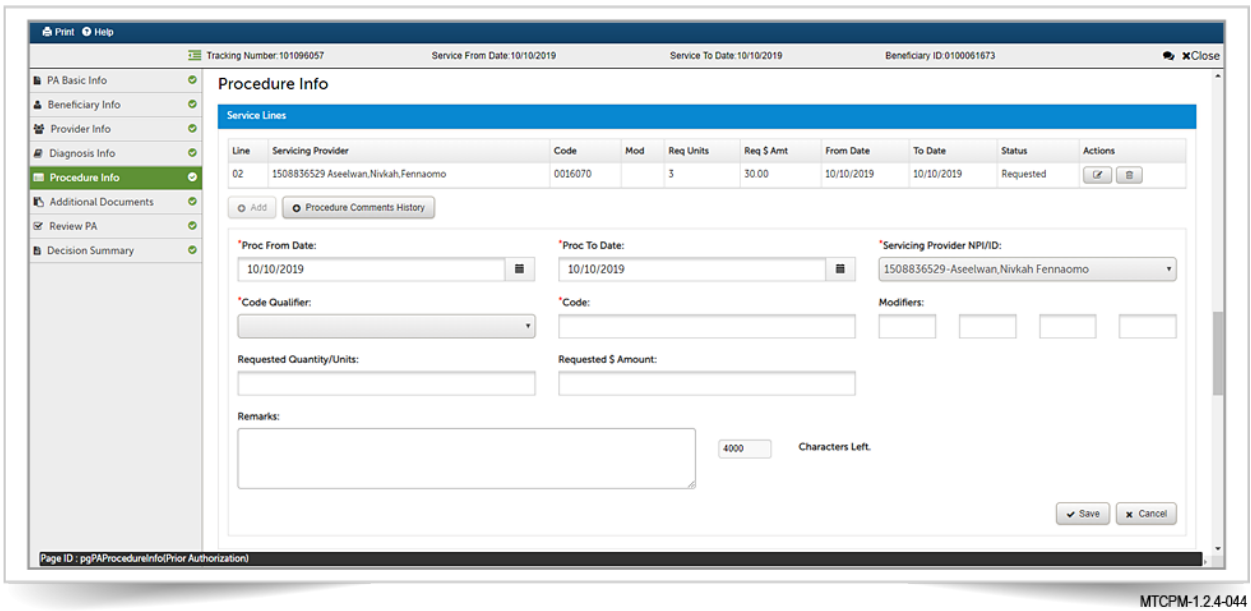


Figure 3.10.15-14. Service Authorization Procedure Details. Team CNSI's evoBrix X Service Authorization module provides extend or limit the effective dates of the authorization.