Managed Care

Members Enrollement	R = Require HD = Highly Desired	State Reporting required CO = CalOMS	State Reporting required C = CSI	Questions
Search for client with at least 3 criteria. Criterias from which to choose must be:	R			
Last Name	R			
First Name	R			
Patient ID	R			
Medical Record Number (MRN)	R			
Social Security Number	R			
Date of Birth	R			
If Client is found and not enrolled:	R			
Screen where enrollment information can be entered, appears.	R			
If Client is not found,	R			
Generate and have the ability to manually create Client ID and MRN	R			
Member Enrollment Data Entry Section: Data in that screen must include:	R			
Last Name	R			
First Name	R			
Gender	R			
The date member is eligible for coverage	R			
This system form must have the capability to be customized, so additional data fields can be created in the form. Data types:	R			
Multi-select data fields	R			
Single select data fields	R			
Open text fields	R			
Primary Contracting Provider field	R			
Ability to search by provider name and ID	R			
Funding Sources to be associated with providers	R			
Funding source can be searched by funding source name or ID	R			
Funding source plans field can be selected, in order to choose the proper plan.	R			
Ability to generate previous enrollments report from the same screen. Report must include:	R			
Member Deletion	R			
Prompt to select the member by ID or name	R			
Delete or Save or Submit button	R			
Member Merge [in case member has been entered more than one]	R			
Member #1 to merge (Retains ID) field. Search by name	R			
Member #2 to merge. This member will be merged, information combined, and then deleted.	R			
Save/Submit button	R			
Member Termination	R			
Previsoulsy gathered data to be displayed in the Member Termination screen	R			
Funding source	R			
Assigned benefit plans	R			
Effective date of funding source enrollment	R			
Ability to enter the termination date	R			
Ability to enter the reason for termination	R			
Ability to add comment about termination	R			
Delete Member Termination to undo member termination and return to active status.	R			
Search for member record by ID or name.	R			
Display the content of termination screen	R			
Save/Submit button	R			
Members Benefit Plan	R			
Allow entry of the same data (listed below), assigned to each funding source for each client.	R			
Assingn a beneift plan; with choice of automatically assinged benefit plan number, or user-selected number for the plan.	R			
Description of the benefit	R			
Start effective date	R			
End expiration date	R			
Deductible Type	R			
Annual	R			
Monthly	R			
Daily	R			
Episodic	R			
Deductible amount	R			
Per Diem Rate	R			
Per Diem Percentage	R			
Insurance Dollar Limit	R			
Maximum Covered Days				
Maximum Covered Partial Days	R			
Maximum Covered Ancillary Charges	R			
Maximum Covered Visits	R			
Maximum Monthly Responsibility	R			
Maximum units of service per day	R			
Maximum amounts per service	R			
Insurance Dollar Limit	R			
Percentage of coverage	R			

Choice of category of practitioner necessary for the coverage.	
Psychiatrist	
Child/Adolescent Psychiatrist	R
Psychiatric or Mental Health Nurse Practitioner	R
Clinical psychologist	R
Clinical social worker	R
Licensed professional counselor	R
Mental Health counselor	R
Certified Alcohol and Drug Abuse counselor	R
Nurse Psychoterapist	R
Marital and Family Therapist	R
Ability to add or edit or remove categories	R
Per Diem Percentage Applies To	R
All services	R
Per diem services	R
Member Authorization	R
Ability to authorize based on multiple funding sources	R
Choose Guarantor/Funding Source; byt funding source name or number	R
Enter Contract Date	R
Enter Contract Notes	R
Assign Authorization Number	R
Assign Authorization Start Date	R
Assign Authorization End Date	R
Choose Service Code (s) with an option to choose "All"	R
Maximum Dollar Amount	R
Maximum Units	R
Maximum Visits	R
Type of Parctitioner necessary for coverage	R
Psychiatrist	R
Child/Adolescent Psychiatrist	R
Psychiatric or Mental Health Nurse Practitioner	R
Clinical psychologist	R
Clinical social worker	R
Licensed professional counselor	R
Mental Health counselor	R
Certified Alcohol and Drug Abuse counselor	R
Nurse Psychoterapist	R
Marital and Family Therapist	R
Ability to add or edit or remove practitioner type	R
Type of Authorization	R
Admission	R
Continued	R
Retroactive	R
Atthending physician reviewing the authorization	R
U/R staff person reviewing the authorization	R
Physician and QM Review date	R
Decertification Date	R
Review Remarks	R
Authorization letters	R
Customizable authorization letters to clients in official county supported languages.	R
Letter Maintenance option	
Flag letters as Sent, Not Sent, Void	HD
Date: Letters requested on or after	HD
Date: Letters requeseted on or before	HD
Date letters were sent	HD
Void letters flagged as Sent or Not Sent	HD
Date: void letters requested on	HD
Date: Void letters sent on	HD
Languages of letters sent	HD
Type of of letters sent	HD
View the letter requested	R
File the letter	R
Print the letter	R
Authorization Tracking	R
Ability to transmit authorization information to providers in various ways:	R
EDI	R
Fax	R
Email	R
Hard Copy	R
Ability to transmit authorizations	R
Single and Multiple Individuals	R
Single and Multiple Organizations	R
Reports to notify of upcoming authorization dates	R
Reports to notify of approaching authorization limits	R
Business Rule Automation	R
Note: This automation ability must be able to be customized and applicable for tracking all processes, including authorization, provider management, provider contract status forms, bed management, and othe similar operational needs.	R
Rule ID	R
Rule Name	R
System or user defined form to which apply the rules	R
Rule Frequency	R
Recurrence Pattern	R
Daily	R
Weekly	R
Monthly	R

Yearly	R
Occurrence Secquence number. For example, '2' for a 'Daily', equals every two days after the event date.	R
Months of the year (Jan, Feb, March,..)	R
Recur Every (Sunday, Monday,...,)	R
Recur On (which day of the month and/or year)	R
Number of days within due date to start notification	R
Rule Effective Date	R
Rule tip - text field to appear	R
Comparison Field Requirements	R
Equal or Not Equal	R
Greater or Less than	R
Greter than/equal to	R
Less than/equal to	R
Includes	R
Does not include	R
Definied	R
Blank	R
Option to compate to a look up dictionary value	R
Option to compare to specific value of a field	R
Comparison Value Date (specific date)	R
Comparison Value Time (specific time)	R
Number of days before/after comparison value	R
Comparison Rule Prerquisites	R
Equal or Not Equal	R
Greater or Less than	R
Greter than/equal to	R
Less than/equal to	R
Includes	R
Does not include	R
Definied	R
Blank	R
Option to compate to a look up dictionary value	R
Option to compare to specific value of a field	R
Provider Management	R
Contracting Provider Registration	R
Search for provider by name or ID. If the one searching for does not exist, allow the ID to be auto assigned as well as manually entered	R
Name	R
Date of Birth	R
Registeration Date (First date provider can perform services for the funding source)	R
Tax Identification Number	R
Office Address- Street	R
Office Address- City	R
Office Address - State	R
Office Address -Zip Code	R
Office Address - Telephone (1)	R
Office Address - Telephone (2)	R
Office Address - Fax Number	R
Pager Number	R
Cellular Number	R
Home Address - Street	R
Home Address - City	R
Home Address - State	R
Home Address - Zip Code	R
Home Phone Number	R
Gender	R
Ethnic Origin	R
Languages Spoken (multiple fields). Look up via smart search or drop down	R
Malpractice Insurance Company	R
Malpractice Policy Number	R
Malpractice Expiration Date	R
Associate contracting providers to funding sources,	R
Start Date	R
Funding Source	R
Assign service authorizations to the provider	R
Associate providers with treatment programs.	R
Assign providers to a bucket of service codes to be used across their population and that does not require a client-level authorization to be completed	R
Define scheduled payments for a contracting provider	R
Contracting Provider Group Registration	R
Collect business related information	R
Business name, address, Tax ID number, etc.	R
Business Address	R
Business Tax ID Number	R
Business NPI Number	R
Business Taxonomy Code	R
All individual practitioner information listed in section in cell 195B	R
Managed Care Authorization by Provider	R
Choose practitioner	R
Maximum Dollar Amount	R
Maximum Units	R
Maximum Visits	R
Contract Management	R
Contract administration tools to:	R

Catalog Contracts	R
Track Contract	R
Monitor Contracts	R
Support multiple contract agreements for per diem and pro fees	R
Ability to scan and attach individual agreements in PDF form	R
Capitated Contracts	R
Must have provisions for:	R
Setting up and configuring capitated contracts	R
Allowing processing payments agreed upon in capitated contracts	R
Allowing tracking payments agreed upon in capitated contracts	R
Must provide capitation-related reports	R
Claims Processing	R
The claims process reconciles claims for provider services	
Batch Creation	R
Batch creation form to group claims to be reconciled at one time	R
Ability to add claims to the batch	R
Ability to close the batch	R
Services can be entered for an active member and funding source	R
When the form is submitted a separate batch is created for each funding source	R
A summary field displays services entered	R
Create Vouchers	R
Ability to create vouchers for all providers	R
Ability to create voucher for an individual provider	R
Ability to enter maximum dollar amount for each voucher	R
Ability to enter the date to create vouchers for batches	R
Ability to enter the start date for services to be included in the voucher	R
Ability to enter the end date for services to be included in the voucher	R
Ability to select whether the vouchers to be created will include only Approved Services, or only Denied Services.	R
The total dollar amount for all vouchers should be able to be displayed	R
Create EOB	R
The EOB form must define the maximum reimbursement per EOB	R
EOBs must reconcile claims submitted by providing contractors	R
Services must be included on a voucher before an EOB can be created that contains the service	R
Multiple vouchers must be able to be contained in a single EOB	R
An EOB must contain at least one voucher	R
Vouchers should not be split between EOBs	R
The maximum dollar amount that can be included in the EOB should be able to be entered	R
The maximum dollar amount to distribute for the current form session should be able to be entered	R
Batches where the date entered is the current date, or earlier can be included in the EOB	R
Ability to include all batched in the EOB should exist	R
Ability to select if EOBs to be created will include only Approved Vouchers or only Denied Vouchers. Also ability to include both	R
Claim Reports	R
Can produce claim reports that can:	R
Include or exclude paid, pending and denied claim information for specific providers, or ranges of providers or facilities	R
Include or exclude paid, pending and denied claim information for facilities	R
Include or exclude paid, pending and denied claim information for ranges of providers or facilities	R
Claims Adjustments	R
Can support the entry of claim adjustments where claims have been entered, adjudicated, approved and paid can be reversed.	R
These adjustments will also need be included in the EOBs for specific providers or facilities.	R
Claims Adjudication component	R
Ability to adjudicate claims on a per claim basis	R
Funding source/insurance company prioritization for claims adjudication	R
Confirmation of existence of an appropriate authorization coverage, for specific service by a specific provider	R
Automtic Adjudication	R
Perform second cycle of adjudication when the batch is closed	R
Claims to be adjudicated based upon the setup of the second adjudication	R
Caseload and Utilization Reporting	R
Must be able to add and remove clients form the case load	R
Must have a notification method (for example to-do list) to notify a user when a client is added or removed form his/her caseload	R
Must have a description field in the case load form	R
Must have a way to record the date when the case load was made or modified	R
Must have reports stating caseload statistics and services provided for the clients in their caseloads.	R
Pricing	R
System must have the ability to:	R
Setup pricing based on programs	R
Setup pricing based on parctitioner category (psychologists, counselors, social workers, etc.)	R
System must have an updatable dictionry for the practitioner categories	R
Setup pricing based on Diagnoses	R
Setup pricing based on CPT codes	R
Setup pricing based on treatment settings (inpatient/residential, outpatient, etc.)	R
System must have an updatable dictionary for treatment settings	R
Setup pricing based on guarantors/funding sources	R

System must have an updatable dictionary for guarantors/funding sources	R
Setup pricing based on categories of guarantors (commerical, Medicare, etc.)	R
System must have an updatable dictionary for categories of guarantors/funding sources	R
Receivables Management	R
Automatically and manually post receivables.	R
Perform check deposit processing.	R
Perform check processing with check register	R
Ability to viewing and reporting of current and historical activities	R
Interface capability with credit card banking	R
Payable Management	R
Supports the per diem payment structure for inpatient and outpatient services	R
Supports multiple reimbursement systems (fee for services, case rate, and capitation).	R
Allow automatic and manual disbursement of money	R
Must have interface capability with check-writing systems	R
Managed Care Reporting	R
Membership Management Reports	R
Reports must include, but not limited to, the following:	R
Active Member Enrollment	R
Member Ledger	R
Ability to generate ledger for individual as well as all providers	R
Report start date	R
The report should detail service costs for a member, and include, but not limited to, the following information:	R
Approval/Pending/Denied status of service authorization	R
Cost of sevice	R
Expected disburse - service cost minus member deductable, or co-pay	R
Service authorization number	R
Charge amount entered in the claims processing form	R
Provider totals	R
Sum ofexpected disbursement for the member	R
Sum of amount billed for the member	R
Members by Authorized Provider	R
Cost of Service by Member	R
Members by treatment setting (inpatient, outpatient, etc.)	R
Members by location	R
HIPAA EDI Transactions	R
Must support the following HIPAA transaction ANSI, ASC X12N EDI standards.	R
270 – Eligibility Request	R
271 – Eligibility Response	R
276 – Claim Status Request	R
277 – Claim Status Response	R
278 – Claim Review Request and Response	R
820 – Premium Payment	R
834 – Enrollment	R
835 – Claim Payment	R
997 – Acknowledgement	R
Call logging	R
Log all calls into a system form that would collect various information about various type of callers; providers, members, etc.	R
Record all the relevant information about a complaint, compliment or grievance related call.	R
The system form must capture call reasons, call status, level of importance, and resolution.	R
Display all previously-gathered patient, plan, and provider data that could assist a service representative during different types of calls.	R
Sources of such data are, but not limited to, enrollment, care management, utilization, benefits and history.	R
They must be rapidly accessible.	R
Have audit trail and tracking reports for all service-call issues that are assigned and routed to the service representatives.	R
The system form must have the option to transfer the service call data into the Care Management forms.	R
Chain the service-call events together, facilitating access to data from several calls related to the same topic and source.	R
Reference unlimited providers for each call issue with separate notes and controls.	R
Data Visualization/ Dashboards	
Dashboards should be customizable and include, but not limited to, the following set of data:	R
All providers by all locations	R
Total outstanding accounts receivables	R
Number of patients	R
Funding sources	R
Unbilled	R
Accounts Receivables by	R
Provider	R
Location	R
Treatment settings	R
Programs	R
Funding sources	R
Number of client visits by	R
Provider	R
Type of provider (Psychologist, Social Work, etc.) List must be an updatable dictionary	R
Location	R
Treatment settings	R
Programs	R
Funding sources	R
Type of diagnoses	R
Number of policies by various categories (customizable by user)	R

Claims by problem type (customizable by user)	R
Claims per day (customizable by user)	R
Number of new clients by day by various variables (customizable by user)	R
Number of cliams billed by various variables (customizable by user)	R
Number of payments	R
Number of Adjustments	R
Number of Denials	R
Net collection	R
Days in accuounts receivable	R
Charges by place of service	R
Charges by provider	R
Charges by Diagnoses	R
Charges by treatment setting	R
charges by program	R
Charges by location	R
Claims by Diagnoses	R
Claims by locations	R
Age receivables	R
Client demographics by various variables (customizable by user)	R