OPERATIONS MANAGEMENT BUSINESS AREA
REFERENCE DATA MANAGEMENT (RF) CHECKLIST

STATE:	DATE OF REVIEW:	REVIEWER:

REFERENCE DATA MANAGEMENT (RF) CHECKLIST

REFERENCE DATA MANAGEMENT (RF) CHECKLIST BACKGROUND

Background for this checklist:

1. Reference Data refers to the body of codes, attributes, and descriptions used by applications within or interfacing with the MMIS. The traditional Reference Subsystem is a composite of applications that periodically update or replace tables of codes.
2. Reference data are created and maintained by many external entities, many of which are named Standard Developing Organizations. Some of these are recognized by HHS as the owners or developers of data standards required by the Health Insurance Portability and Accountability Act (HIPAA).
3. Reference data are also created by State Medicaid agencies. During HIPAA implementation, States mounted an unprecedented effort to reconcile the large number of "Local Codes" that States had invented individually over the past 30 years. This effort resulted in the adoption by most States of the collaboratively approved standards to replace local codes.
4. Reference code sets fall into very large files maintained by external entities, e.g., HCPCS, NCPDP, ICD-9; small files maintained by external entities; and local code files created by the State.
5. Periodicity of file updates or replacements depends on the owner of the data. States usually pay a fee for update services from external entities.
6. Codes are date-specific. The start and end date of a code impacts the pricing or the validity of the information.
7. HIPAA introduced the concept of "mandatory" data standards as opposed to voluntary.

Sources for the criteria in this checklist are as follows:
SMM – State Medicaid Manual, MMIS Section, available from http://www.cms.hhs.gov/Manuals/PBM/list.asp, Document 45
IBP – Industry Best Practices. Items are selected from RFPs for MMISs developed by states and approved by CMS.
HIPAA – HIPAA act, available from
http://www.cms.hhs.gov/TransactionCodeSetsStands/02_TransactionsandCodeSetsRegulations.asp#TopOfPage

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BUSINESS OBJECTIVES		
Reference #	**Business Objectives**	**Comments**
RF1	Manage reference data to support claims processing, data to consist of proper procedure, diagnosis, formulary and drug pricing codes, charge information, and data that supports different payment methods (e.g. Outpatient Prospective Payment System (OPPS), Diagnosis Related Group (DRG), etc), and other items as needed by the State.	
RF2	Comply with Health Insurance Portability and Accountability Act (HIPAA) requirements.	
RFSS1	*Add State-specific business objectives for the Reference Data Management Checklist here.*	

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RF1 – MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1.1	Maintains reasonable and customary charge information for Medicaid and Medicare to support claims processing: ▪ Reimbursement under the Medicaid program for other than outpatient drugs, Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), Indian Health Services (IHS) and hospital inpatient and outpatient reimbursement is to be the lower of the provider's "usual and customary" charge, the rate established by the State, or the amount, which is allowed under the Medicaid program. "Usual and customary" charges are calculated from the actual charges submitted on provider claims for Medicaid payment. ▪ Reimbursement for prescription drugs are usually processed by either a) Federal Upper Limit (FUL) or Maximum Allowable Cost (MAC) with some drugs; the State defined Estimated Acquisition Cost (EAC), which is defined by the Average Wholesale Price (AWP) less 15 to 20 % plus a dispensing fee (ranging anywhere from 0.50 to several dollars); and/or plus a provider specific dispensing fee; or b) the provider's usual and customary charge, paying the lesser of these fees.	SMM			

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RF1 – MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1.2	Supports Payment for Services by providing reference data, including procedure, diagnostic, and formulary codes (42 CFR 447).	SMM			
RF1.3	Processes change transactions to procedure, diagnosis, and formulary codes and other data and responds to queries and report requests.	SMM			
RF1.4	Archives all versions of reference information and update transactions.	IBP			
RF1.5	Processes update transactions to the reasonable and customary charge data and responds to queries and report requests.	SMM			
RF1.6	Retrieves, as needed, archived reference data for processing of outdated claims or for duplicate claims detection.	SMM			
RF1.7	Generates a summary of history file transfers.	IBP			
RF1.8	Maintains current and historical reference data used in claims processing.	IBP			
RF1.9	Maintains online access to all reference tables with inquiry by the appropriate code.	IBP			
RF1.10	Maintains an audit trail of all information changes, including errors in changes and suspended changes.	IBP			

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RF1 – MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1.11	Maintains revenue codes; provides online update and inquiry access, including: (a) Coverage information (b) Restrictions (c) Service limitations (d) Automatic error codes (e) Pricing data (f) Effective dates for all items	IBP			
RF1.12	Maintains date sensitive parameters for all Reference Data Management data.	IBP			
RF1.13	Maintains current and historical coverage status and pricing information on legend drugs, Over The Counter (OTC) items, and injection codes.	IBP			
RF1.14	Supports code sets for the payment of Medicaid-covered non-health care services, e.g. waiver services.	HIPAA			
RF1.15	Maintains the drug-pricing file, updating it at scheduled cycle.	IBP			
RF1.16	Maintains the trauma indicators to identify potential Third Party Liability (TPL) cases.	SMM			
RF1.17	Maintains diagnosis and procedure code narrative descriptions of each code contained in the files.	IBP			
RF1.18	Updates all procedure, diagnosis and drug files if required prior to each payment cycle.	SMM			

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RF1 – MANAGE REFERENCE DATA TO SUPPORT CLAIMS PROCESSING					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF1SS.1	*Add first State-specific criterion for this business objective here. Example: Accommodates retroactive rate changes as they relate to medical procedures and limitations.* *Example: Maintains current and 10 years of historical date-sensitive NDC Drug Code information.* *Example: Accommodates weekly updates of NDC drug file.*				

RF2 – COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF2.1	Manages HIPAA-required external data sets (e.g., ICD-9; NDC).	HIPAA			

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RF2 – COMPLY WITH HIPAA REQUIREMENTS					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RF2.2	Maintains all data sets defined by the HIPAA Implementation Guides to support all transactions required under HIPAA Administrative Simplification Rule (e.g., Gender, Reason Code).	HIPAA			
RF2SS.1	*Add State-specific criteria for this business objective here.* *Example: Demonstrates flexibility to accommodate newer versions of the ICD diagnosis codes.* *Example: Demonstrates flexibility to accommodate newer versions of the HCPCS and CPT procedure codes.* *Example: Maintains data sets defined in the Implementation Guides for the 824, 277, 997 or 999 X12N acknowledgement transactions.*				

RFSS1 – FIRST STATE-SPECIFIC BUSINESS OBJECTIVE					
Ref #	**System Review Criteria**	**Source**	**Yes**	**No**	**Comments**
RFSS1.1	*Add criteria based on the APD, RFP, etc., that are relevant to this State-specific objective.*				