

Proposer's Name: _____

RFP No: DMH-1109B2

APPENDIX B.1

FUNCTIONAL REQUIREMENTS RESPONSE



Integrated Behavioral Health Information System



Table of Contents

Instructions
Section I - Referral-In
Section II - Screening
Section III - Authorization
Section IV - Intake
Section V - Service Delivery
Section VI - Billing
Section VII - Closure
Section VIII - Claims
Section IX - Portals



FUNCTIONAL REQUIREMENTS RESPONSE INSTRUCTIONS

Capitalize terms used in this Appendix B.1 without definition herein shall have all meanings given to such terms in the body of Appendix E (Sample Agreement), Appendix A (Statement of Work) or Appendix F (Glossary).

The Functional requirements set forth in this Appendix B.1 (Functional Requirements Response), for the IBHIS RFP are grouped by functionality and are contained in a Microsoft Excel workbook designed to be a self-scoring matrix. The matrix has been designed to require a single response in the appropriate Response Column A, B, C, D, or E for every numbered requirement within each respective section. Only one entry per numbered requirement is permitted. Proposer shall not place responses in columns that are shaded or unnumbered, alter, insert rows or add data to the matrix.

Complete and submit information as requested for each and every required Section [i.e., Section I (Referral-In), Section II (Screening), Section III (Authorization), Section IV (Intake), Section V (Service Delivery), Section VI (Billing), Section VII (Closure), Section VIII (Claims), and Section IX (Portals)].

[Note: A document substantially similar to this Appendix B.1 shall become Attachment B.1 (Functional Requirements) to Exhibit B (Technical Solution Requirements) of any resultant Agreement.]

IMPORTANT: Proposer must not leave any numbered requirement response column blank within each respective section. Failure to provide a response to any numbered requirement will be deemed “Non-Responsive.” Multiple responses to any numbered requirement will also be deemed “Non-Responsive.” Responses that are deemed “Non-Responsive” will result in a zero (0) point score or may, in County’s sole discretion, result in disqualification or elimination of the proposal. County in its sole discretion may elect to adjust Proposer’s scores where discrepancies between Proposer’s comments and score exist.

For each numbered requirement, place a number one (1) in only one of Response Column A, B, C, D, or E. The definitions of the columns are as follows:

* **A = Currently available**

The functionality described in the requirement statement is available in the current release of the proposed System Software without modification or the use of Third Party Software.

* **B = Development**

The functionality described in the requirement statement is not available in the current release of the proposed System Software but is or will be under development and added to the general commercial release and available for Production Use by July 1, 2010.



FUNCTIONAL REQUIREMENTS RESPONSE INSTRUCTIONS

* **C = Available via vendor modification**

The functionality described in the requirement statement requires vendor modification ("Custom Programming Modifications") to the current release of the proposed System Software. No Third Party Software is required to provide the stated functionality.

Proposer must additionally include a corresponding entry in Section III.A (Professional Services: Custom Programming Modifications) of Appendix C (Price and Schedule of Payments) in respect of the applicable Custom Programming Modification, even if the cost is a zero (\$0.00) dollar amount, for each requirement with this response.

All software modification services and/or Work associated with a response of C shall be performed as set forth in Appendix A (Statement of Work), and in accordance with Appendix E (Sample Agreement).

* **D = Available using Third Party Software**

Proposer must list the Third Party Software in the Comments column and include corresponding entries in Sections: I.B (System Software: Third Party Software) and III.B (Professional Services: Interfaces) of Appendix C (Price and Schedule of Payments) to include the cost of both the applicable license(s) and any related integration services and/or other Work, even if the cost is a zero (\$0.00) dollar amount, for each requirement with this response.

Any related Third Party Software integration services and/or Work associated with a response of D shall be performed as set forth in Appendix A (Statement of Work), and in accordance with Appendix E (Sample Agreement).

* **E = Not available**

The functionality described in the requirement statement is not available in the current release of the proposed System Software and is not targeted to be in general commercial release and available for Production Use by July 1, 2010.

* **Comments**

In addition to listing any applicable Third Party Software, the Comments column can be used to qualify answers or add notes that may further explain how the proposed software achieves the desired functionality.

**Functional Requirements Matrix
Section I - Referral-In**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Referral-In							
Contact Management / Call Logging							
1	Ability to log contacts (i.e., incoming telephone calls and walk-in inquiries) and store the information in an on-line database						
2	Provides real-time logging and data collection during contact inquiry						
3	Provides prompting during contact dialogue						
4	Ability to create a user-defined on-line form for capturing contact information						
	Ability to capture and retain the following data fields:						
5	Contact name						
6	Additional identifier						
7	Date of call set by System						
8	Time of call set by System						
9	Telephone number(s)						
10	Language requirement						
11	E-mail address						
12	Referring party						
13	Referring party telephone number						
14	Referring party fax number						
15	Referring party address						
16	Staff member responding is set by System						
17	Type of contact						
18	Notes area						
19	Reason field						
20	User-defined fields						
21	Ability to record client contact information without the requirement of opening a case						
22	Ability to identify and link repeat contacts						
23	Ability to view contact histories						

**Functional Requirements Matrix
Section I - Referral-In**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement	A	B	C	D	E	Comments
24 Assigns a unique number to each contact for identification and tracking purposes						
25 Provides decision tree logic based on the type of call or incident for prompting operator						
26 Prompts User to route calls according to user-defined guidelines						
27 Automatically assigns the call to staff for research and resolution (workflow integration)						
28 Automatically escalates calls according to user-defined time and priority criteria						
29 Ability to document contact and disposition						
30 Provides reports on contact statistics						
31 Provides geographical search capability to provider network information						
32 Accesses and / or links to the information and referral database						
33 Provides both inbound and outbound electronic referral capability						
Referral Management						
34 Ability to record and store name of individual or program referring client into department						
35 Ability to record notes associated with referral sources						
36 Ability to set reminders and triggers for staff based on referral information						
Community Resource Database						
37 Ability to create and maintain a community resource database used specifically to make referrals						
38 Ability to search database online						
39 Provides for access to community resource database from elsewhere in the System						
40 Provides a community resource database which is separate from the provider database						
Ability to capture the following data fields:						
41 Name of resource						
42 Address of resource						
43 Telephone number(s) of resource						
44 Fax number of resource						
45 Website of resource						
46 Description of services						

**Functional Requirements Matrix
Section I - Referral-In**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
47	Hours of operation						
48	Contact name (administrative)						
49	Contact telephone number						
50	Contact e-mail address						
51	Resource status (active / inactive)						
52	Date resource record created						
53	Date resource record last updated						
54	User name, date, and time tracking of all updates made to resource record						
55	User-defined fields						

**Functional Requirements Matrix
Section II - Screening**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Screening / Triage							
	Client Inquiry / Look-up						
56	Provides inquiry or search feature to determine if a client is new to the System						
	Client search features utilize the following techniques to locate existing client records:						
57	Soundex						
58	Other search algorithms						
	Ability to search or inquire for a client by:						
59	Client name						
60	Partial name						
61	Aliases						
62	Date of birth						
63	Social Security number						
64	Internal client ID number						
65	Combinations of the above						
66	Provides probabilistic capabilities on combinations of search criteria						
67	Provides seamless access to client registration if client is not already in the System						
68	Ability to define alert conditions and corresponding messages that will appear when viewing an individual client record						
	Ability to set alerts in the client record for the following conditions:						
69	Missing data elements						
70	Bad debt indicator						
71	Ability to display multiple messages and alerts						
72	Includes message setting and display functionality based on User security levels						
73	Ability to set prompt intervals for message alerts to staff for updating client demographic information						
	Screening / Triage						
74	Ability to create user-defined on-line forms to assist in the determination of which services the client requires						
75	Ability to access historical client demographic and episode data						
76	Ability to add user-defined fields for staff to track screening and triage efforts						

**Functional Requirements Matrix
Section II - Screening**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Wait List Management							
77	Ability to maintain a wait list (e.g., Request for Service Log)						
78	Provides an on-line data entry screen with user-defined fields for wait list						
79	Ability to update wait list information as client circumstances change						
	Ability to generate Request for Service logs (wait lists) containing the following client information:						
80	Date and time of entry						
81	Referral type						
82	Reason for wait list						
83	Priority						
84	Expected appointment date						
85	Program or benefit information						
86	User-defined fields						
87	Ability to generate reports of wait listed clients						
88	Tracks User, time and date of updates to wait list						
89	Ability to set triggers based on date for actions						
Benefits Establishment							
90	Provides reporting capability to identify clients that may be eligible for Medi-Cal based on multiple criteria						
91	Ability to set reminder ticklers in client record to take follow-up action on or after a certain date						

**Functional Requirements Matrix
Section III - Authorization**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Authorizations							
Creation and Receipt of Service Authorizations							
	Ability to create service authorization requests for the following types of services:						
92	Inpatient						
93	Residential						
94	Emergency services						
95	Outpatient services						
96	Wrap around services						
97	Ability to add new types of service authorizations as necessary						
98	Ability to accept, capture, store and generate an ASC X12N 278 - Referral Certification and Authorization transaction						
99	Ability to create authorization requests through a secure web-enabled portal						
100	Automatically detects potential duplicate authorization requests upon entry						
101	Ability to review and override authorization status						
Processing of Service Authorizations							
102	Ability to create and attach a user-defined status indicator to a service authorization						
103	Ability to approve, deny or defer a service authorization request						
104	Ability to automatically generate Notice of Action letters with user-defined responses						
105	Ability to track Notice of Action letters sent						
106	Ability to track the status of a service authorization request						
107	Provides workflow-related rules to direct the flow of service authorizations						
108	Provides unlimited authorization level notes with date stamp and time stamp						
109	Provides role-based access capability for notes, status determination and opening and closing of service authorization requests						
110	Provides capability to verify authorized services against benefit plan and accumulators before approving						
111	Authorization module interfaces with client master file						
112	Authorization module interfaces with provider master file						
113	Provides automatic verification of client eligibility at time of authorization request entry						
114	Automatically verifies provider contract status at time of authorization request entry						

**Functional Requirements Matrix
Section III - Authorization**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
115	Offers different authorization screen formats based on type of service (e.g., inpatient, outpatient)						
	Ability to automatically inactivate authorizations:						
116	After a user-defined period of time without receipt of claims						
117	Upon member termination						
118	When referral provider terminates contract						
	Authorized services can be stipulated by:						
119	Procedure code groupings						
120	HCPCS groupings						
121	ICD-9 or DSM-IV codes						
122	Provider						
123	Provider taxonomy						
124	Place of service						
125	Provides linkage to clinical protocols to review guidelines and alternatives prior to authorizing specific procedures for a given diagnosis or condition						
	Ability to set and track limits on authorization based on any or all of the following data elements:						
126	Number of visits						
127	Units of service						
128	Level of service codes						
129	Date parameters						
130	Cost (dollars)						
131	Interfaces with claims adjudication module to update authorization accumulators						
132	Automatically sets authorization status to closed when all services have been claimed and claims have been adjudicated						
133	Ability to link multiple authorizations for an individual client						

**Functional Requirements Matrix
Section III - Authorization**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
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Requirement		A	B	C	D	E	Comments
FFS Inpatient Requirements							
134	Ability to generate authorizations and authorization data that meets the State Treatment Authorization Request (TAR) specifications						
135	Ability to submit approved TARs to the State fiscal intermediary electronically						
136	Ability to generate a State TAR Update Transmittal (TUT) form						
137	Sets field indicators for medical necessity reviews and decisions						
138	Ability to enter State TAR appeal level information						
Reporting							
	Provides reporting capability to capture statistics for:						
139	Submissions						
140	Approvals						
141	Denials						
142	Provider type						
143	Age of Authorization						
144	Other						
	Ability to produce the following reports:						
145	Authorization turnaround reports						
146	Authorization productivity reports by authorizing User						
	Trending of authorizations by:						
147	Referring provider						
148	Referred to provider						
149	Referred to provider specialty						
150	Status (approved / denied / pended)						
151	Combinations of the above						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Intake - Registration, Financial Screening, Eligibility							
Client Registration - General							
152	Permits a single client record to be used across multiple modules						
153	Provides a Master Patient Index (MPI)						
154	Ability to record a unique client ID number						
155	Ability to generate a unique client ID number						
156	Availability of all client registration data in all modules as needed, without the need for duplicate entry of information						
	Provides on-line, real-time registration feature for gathering and retrieving the following information:						
157	Client information						
158	Financial information						
159	Clinical data information						
160	Includes the ability to upload demographic and financial data						
161	Once entered, all demographic and financial fields can be used on user-defined on-line forms, reports generation and printable documents						
162	Ability to track clients by means of a client status with user-defined levels (e.g., pre-registered, discharged, etc.)						
163	Provides inquiry and search capability with duplicate record checking						
164	Provides cross check of name inquiries to identify alias names						
165	Ability to link family members						
166	Retains history of all changes to each registration field, including User, date and time, previous entry						
167	Utilizes pop up windows or other method to select from pre-defined tables or dictionaries (e.g., dictionary of city names, zip codes, referral sources)						
168	Ability to create user-defined fields						
169	Ability for user-definition of which fields are required for registration process to be complete						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

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E=Not available

Requirement		A	B	C	D	E	Comments
	Includes duplicate record management options:						
170	Merge records						
171	Deactivate records						
172	Reactivate records						
173	Ability to display potential duplicate client records on screen simultaneously for review						
174	Ability to interface with third party Master Patient Index (MPI)						
Demographic Information							
Client							
	Ability to collect client demographic data, including:						
175	Client first name, last name, middle name, suffix						
176	Multiple client alias						
177	Client address, city, state, zip code						
178	Client "homeless" indicator						
	Client phone numbers:						
179	Home						
180	Work						
181	Mobile						
182	Other						
183	Client employer name						
184	Client employer address						
185	Multiple client employers						
186	Client e-mail address						
187	Client Social Security number						
188	Client date of birth						
189	Client sex						
190	Client marital status						
191	Client ethnicity						
192	Client primary language						
193	Client referral source (how client was referred)						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
194	Client legal status						
195	Ability to assign multiple legal statuses to a single client						
	Ability to record the date of client signature on the following forms:						
196	Consent forms						
197	Client assignment of benefits information						
198	HIPAA notification forms information						
199	Advance Directive indication						
200	Other user-defined forms						
201	Ability to set a date associated with forms as a reminder to take future action						
	Ability to integrate external documents into the clinical record, including:						
202	Scanned documents						
203	Electronically stored documents						
204	Images						
205	Ability to access integrated documents and images from within the client record						
	Collateral Contacts						
206	Ability to record multiple collateral contacts per client						
	Ability to collect demographic data for each collateral contact, including:						
207	Collateral contact first name, last name, middle name, suffix						
208	Collateral contact address, city, state, zip code						
	Collateral contact phone numbers:						
209	Home						
210	Work						
211	Mobile						
212	Other						
213	Collateral contact employer name						
214	Collateral contact employer address						
215	Multiple collateral employers						
216	Collateral contact Social Security number						
217	Collateral contact date of birth						
218	Collateral contact gender						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
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Requirement		A	B	C	D	E	Comments
219	Collateral contact marital status						
220	Collateral contact relationship to client						
221	Client consent to collateral contact receipt of information						
222	Ability to capture effective and termination dates of collateral contact relationship (e.g., LPS conservatorship, Payeeship)						
223	Ability to record other user-defined public agencies involved with the client						
224	Ability to link one collateral contact to multiple clients						
225	Ability to capture effective and termination dates of collateral contact						
226	Retains history or archive of previous collateral contacts associated with a client						
Insurance							
227	Maintains all current and historic insurance company information, including subscriber and effective dates						
228	Ability to record multiple active insurance carriers with primary, secondary and tertiary notation						
229	Classifies insurance carrier into user-defined financial class categories for billing rules and reporting purposes						
230	Prompts User to obtain preauthorization if required						
	Ability to collect insurance coverage data, including:						
231	Insurance carrier name						
232	Insurance carrier address						
233	Insurance carrier city						
234	Insurance carrier state						
235	Insurance carrier zip code						
236	Insurance carrier phone number						
237	Group name						
238	Group number						
239	Subscriber ID number						
240	Client ID number						
241	Client relationship to subscriber						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
242	If self, auto-populate with client information						
243	If collateral contact, auto-populate with collateral contact information						
244	Subscriber first name, last name, middle name, suffix						
245	Subscriber address, city, state, zip code						
	Subscriber phone numbers:						
246	Home						
247	Work						
248	Mobile						
249	Other						
250	Subscriber employer name						
251	Subscriber employer address						
252	Subscriber Social Security number						
253	Subscriber date of birth						
254	Subscriber gender						
255	Subscriber marital status						
256	Coverage primary, secondary and tertiary						
257	Coverage effective and termination dates						
Financial Screening / California UMDAP							
	Provides on-line, real-time financial assessment feature, for gathering and determining financial responsibility, including:						
258	Other Insurance						
259	UMDAP						
260	Provides annual tickler for required UMDAP re-determination						
261	Ability to produce printed forms to be given to clients at the conclusion of the financial assessment process						
Eligibility and Insurance Verification							
Eligibility Loading							
262	Ability to load monthly Medi-Cal eligibility file from the state						
263	Updates Medi-Cal eligibility records for all eligible enrollees each month, including all retroactive changes received						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
264	Alerts staff of retroactive additions and removals that may have an impact on claims						
265	Maintains eligibility records for all county eligibles in the state monthly download file, not just individuals who are enrolled as clients						
266	Provides eligibility loading, processing and automatic update capabilities for Medicare						
267	Provides eligibility loading, processing and automatic update capabilities for other insurance companies and health plans						
Eligibility Verification							
268	Provides for eligibility of registered clients to be evaluated against the downloaded eligibility files and updated as necessary based on a matching algorithm						
269	Provides a real-time interface to the Medi-Cal Point of Service MEDS database for viewing a client's current eligibility status for Medi-Cal and other healthcare coverage information						
	Ability to review and update client records for special handling conditions including:						
270	Partial eligibility match requiring investigation						
271	Medi-Cal Share of Cost						
272	State Aid codes						
273	Medicare						
274	Other County responsibility						
275	Ability to record the Medi-Cal Eligibility Verification Code (EVC)						
276	Ability to enter the Medi-Cal Primary Aid Code and County Code						
277	Ability to record a client's Share of Cost obligation and ensure that those services are not billed to Medi-Cal						
278	Ability to clear a client's Share of Cost obligation						
279	Provides an algorithm to identify clients with changes in eligibility status and retroactive billing opportunities						
280	Ability to define multiple pharmacy benefits plans for a client						
Eligibility Information Access							
281	Provides access to a client's eligibility records from other System modules (e.g., Call Logging, Appointment Scheduling, Registration)						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement	A	B	C	D	E	Comments
Initial Assessment						
282 Ability to create user-defined assessment forms						
283 Ability to integrate with third party licensed assessment tools						
Assessment forms provide:						
284 Free text entry						
285 Point-and-click choice						
286 Drop down menus						
DSM Assignment						
287 Ability to use of DSM IV codes						
288 Ability to collect Axis I - Axis V data						
289 Ability to record multiple diagnoses by Axis						
290 Ability to designate one diagnosis as 'primary'						
291 Ability to look-up DSM-IV codes by partial description						
292 Ability to use ICD-9 codes						
293 Ability to use ICD-10 codes						
294 Provides a cross-walk table to translate diagnoses from one classification system to another						
295 Ability to enter and track multiple diagnoses						
Clinician Assignment						
296 Ability to assign and track a case coordinator						
297 Displays the case coordinator in the client's demographic information						
298 Ability to assign only one case coordinator to a client at any given time						
299 Ability to associate a client to a treatment team						
300 Maintains history of case coordinator / case manager / SFPR assignments with effective dates						
301 Ability to associate multiple providers with a single episode of care						
302 Ability to define rules that generate alerts						
303 Ability to associate user-defined alerts to a client record						
304 Ability to notify assigned clinician based upon user-defined alerts						

**Functional Requirements Matrix
Section IV - Intake**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
	Medical History						
305	Ability to record client's past medical history						
306	Ability to record client's behavioral health treatment history						
307	Ability to record client's family history						
308	Ability to record client's social history						
	Ability to record client's medication history including:						
309	Prescription Medications						
310	Over the counter medications						
311	Vitamins and herbal supplements						
	Ability to record client's allergy information including:						
312	Medication allergy						
313	Food allergy						
314	Other allergy						
315	Ability to record client's current medical conditions						
	Episode Management						
316	Ability to define and track episodes of care for clients						
317	Ability to open and close client episodes as appropriate						
318	Ability to have multiple client episodes open at same time						
	Provides standard statistical reporting on episodes, including:						
	Number of open episodes by:						
319	Provider						
320	Location						
321	Diagnosis						
	Number of episodes opened / closed during a particular period of time by:						
322	Provider						
323	Location						
324	Diagnosis						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Service Delivery							
Appointment Scheduling							
325	Provides on-line scheduling of appointments for client services						
	Ability to enter the following information in the appointment screen:						
326	Client name						
327	Client phone number						
328	Presenting problem						
329	Symptoms						
330	Referral source						
331	Authorization number						
332	Comments (e.g., symptoms, pre-medication advisory, language needs)						
333	Ability to schedule recurring services for a client with one entry (e.g., bi-monthly for three months)						
334	Ability to schedule clinicians, therapists and other direct service providers						
335	Ability to schedule sites						
336	Ability to schedule equipment						
337	Ability to schedule out of the office activities						
338	Ability to create appointment templates by individual clinicians or resource						
339	Provides on-line graphic displays of schedules and available slots						
340	Ability to display more than one day's schedule at a time						
341	Ability to schedule add-in clients (i.e., add a client to schedule without a time slot)						
342	Ability to schedule more than one client at a time (i.e., dual or group sessions)						
343	Ability to double-book clients						
344	Ability to double-book clinicians staff and resources						
345	Displays a pop-up calendar on demand						
346	Automatically records identity of User entering appointment information						
347	Ability to schedule new clients with incomplete client demographic information						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
	Ability to automatically find available appointment slot for a client in the following ways:						
348	Next available slot						
349	By day of week						
350	By time of day						
351	By length of appointment						
352	By clinician						
353	By type of appointment						
354	By office or location						
355	Ability to add an appointment						
356	Ability to cancel an appointment						
357	Ability to change an appointment						
358	Ability to reschedule appointments without having to re-enter data						
359	Ability to reschedule bumped clients						
360	Tracks and manages schedule changes (e.g., bumped clients, cancellations, no-shows)						
361	Ability to reassign (e.g., move) appointments to another clinician						
362	Ability to schedule multiple services for a client to be performed at multiple sites						
363	Ability to schedule two or more resources simultaneously						
364	Ability to perform wave scheduling (i.e., set up appointments by type in time slots)						
365	Ability to schedule blocks of time for specific procedures or services						
366	Ability to schedule blocks of times for clinicians						
	Prints daily appointment list containing:						
367	Appointment information						
368	Client account status						
369	Client notes						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
	Ability to generate appointment lists in the following ways:						
370	By clinician						
371	By office or location						
372	By type of appointment						
373	For current day						
374	By date and time						
375	By date range						
376	By equipment, resource type, or both						
377	Ability to generate confirmation lists for staff to call and confirm the appointment on the business day prior to the appointment						
378	Generates a list of appointments for chart pulling on demand						
379	Ability to generate route slips						
380	Ability to generate encounter forms						
381	Ability to generate fee slips						
382	Ability to generate client recall notices						
383	Ability to print recall lists						
	Ability to generate the following reports:						
384	Cancellations						
385	No-shows						
386	Appointments kept						
387	Missing charges						
	Appointment Check-In						
388	Ability to indicate a client has appeared for their appointment						
389	Ability to automatically notify clinician that client has checked-in for their appointment						
390	Ability to indicate that a client was a "walk-in"						
391	Assigns a tracking number for all clients appearing, including walk-ins						
392	Ability to reconcile check-ins with service capture and charge entry						
393	Ability to monitor clients within clinic after check in						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

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Requirement		A	B	C	D	E	Comments
Workflow Support							
394	Provides each clinician with display and printed listing of his or her clients that are active and open						
395	Provides tools for planning and organizing the clinicians' work						
396	Provides a summary level user-defined screen (e.g., in-box or dashboard) which can be customized by the clinician to assist with workflow organization						
397	Provides on-line authorized access to a client's historical clinical data including past diagnoses, treatment plans, services and medications						
398	Ability to create multiple views of clinical history						
399	Ability to "flip through" the client data in a manner similar to reviewing a paper chart						
400	Ability to define program or pharmacy benefit plan eligibility based on financial, client and utilization criteria						
401	Ability to flag a provider when a client meets program or pharmacy benefit plan eligibility criteria						
Service Documentation							
General Documentation							
402	Provides on-line charting and documentation						
	Provides multiple types of service documentation, including:						
403	Pre-defined treatment plans						
404	Online progress notes						
	Provides multiple methods of service documentation:						
405	Free text entry						
406	Spell check functionality						
407	Drop down menus						
408	Point-and-click selection						
409	Ability to record notes by speaking through voice recognition software						
410	Special services						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

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Requirement	A	B	C	D	E	Comments
411 Provides spell-check of service documentation notes						
412 Ability to record treatment goals						
413 Ability to track progress against treatment goals						
414 Links progress notes to treatment plan and goals in treatment plan						
415 Prompts provider to complete documentation pertinent to a particular condition or program						
416 Includes clinical database of evidence-based practice guidelines						
417 Ability to establish user-defined evidence-based practice guidelines						
418 Includes the ability to document and trend quantitative test results						
419 Documentation of client service automatically drives service capture or transactions						
Includes electronic signature capability, including the following:						
420 Provides for electronic provider signature						
421 Allows multiple providers to sign a single record						
422 Permits electronic co-signatures						
423 Locks the record from editing once signed						
424 Ability to amend documentation after signing and locking						
425 Provides on-line prompts where signatures or co-signatures are required in the completion of medical records documentation to avoid charting deficiencies						
426 Provides authorization hierarchy for sign-off						
427 Records User, date and time of each modification (e.g., update, change, deletion) to the clinical record						
428 Ability to sort progress notes for viewing in chronological or reverse chronological order by encounter date						
429 Ability to sort progress notes for viewing by type of service						
Client Care / Coordination Plan						
Provides user-defined treatment plan and crisis management plan templates customizable by multiple variables including:						
430 Location						
431 Program						
432 Target population						
433 Ability to develop treatment plan libraries						
434 Ability to print treatment plan for client review and signature						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
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Requirement	A	B	C	D	E	Comments
Special Services						
Group Services						
435 Provides management of group services						
436 Ability to add and delete clients from groups						
437 Provides single screen documentation and service entry for entire group						
438 Provides independent recording of therapist and co-therapist time						
Mobile Operations						
439 Ability to remotely access the System via mobile devices (e.g., laptops, PDAs, tablets)						
440 Ability to perform client inquiry or search from remote locations (e.g., outside of the office)						
441 Ability to access client records from remote location						
442 Ability to access personal work queues from remote location						
443 Ability to document services from remote location						
Case Management						
Ability for staff to update parts of the client record including:						
444 Medical history						
445 Medication history						
446 Educational history						
447 Socialization progress						
448 Vocational history						
449 Rehab history						
450 Community service activity						
451 Ability to create rules to identify when case management services are billable vs. non-billable						
Client Linkage Activities						
452 Provides tools to document and track all client referrals in and out of the clinic, department or program						

**Functional Requirements Matrix
Section V - Service Delivery**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software

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Requirement		A	B	C	D	E	Comments
Order Entry							
Laboratory							
453	Provides for on-line order entry for laboratory tests						
454	Ability to upload lab order results from a HIPAA compliant laboratory system						
455	Ability to print laboratory orders						
456	Ability to transmit a HIPAA compliant electronic laboratory order						
457	Ability to schedule lab draws done on-site						
458	Ability to send lab results electronically to provider in-box for review						
459	Alerts staff when lab results are outside of normal limits						
460	Stores and provides authorized on-line access to historical lab results						
Medication Management							
Provides for on-line order entry for pharmacy requests, with options to:							
461	Write a pharmacy order to the client's medical record						
462	Print a prescription from the client's medical record						
463	Captures client medication allergy data						
464	Includes presentation of client medication allergy information to providers						
465	Displays and captures client food and herbal allergy information to providers						
466	Pharmacy orders remain "open" until filled notification received						
467	Adds the pharmacy prescription number to medical history						
468	Ability to document dispensed sample medications						
Provides a comprehensive medication history including the following information:							
469	Medication order added to medication history						
470	Medication history updated upon filled notification						
471	Generates client consent forms by medication						
472	Associate signed medication consent forms with applicable prescriptions						
473	Display indicator that there is a signed consent form with applicable prescription						
Ability to print medication instruction sheet for client including the following items:							
474	Dosage						
475	Administration instructions						
476	Description of medication						
477	Side effects						
478	Adverse reactions						
479	Provides alerts to providers if lab testing is recommended						

**Functional Requirements Matrix
Section V - Service Delivery**

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Requirement	A	B	C	D	E	Comments
Medication Reporting						
480						Ability to create user-defined reports
						Includes the following standard reports:
481						List of clients with prescriptions expiring
482						List of clients currently or previously on a particular medication(s)
						Reports, by time period, of prescribed medications by:
483						Prescriber
484						Clinic
485						Medication requested
486						Medication dispensed
487						Dispenser of medication
488						Client
489						Diagnosis
Medical Record Management						
490						Ability to define one or more reports as the formal health record for disclosure purposes
491						Ability to generate hardcopy print of all or part of the medical record
492						Ability to generate electronic copies of all or part of the medical record
493						Maintains administrative files that catalog requests and release of medical record information
494						Maintains administrative files that catalog receipt of and information released via subpoena
495						Maintains administrative files that catalog medical record information requested and released in cases involving litigation
496						Automatically track billing and payment information related to medical record correspondence
Quality Management / Reporting						
497						Ability to create user-defined outcome measures
498						Ability to generate outcome measure reports
499						Provides client, service, and outcome measure reporting based on SDMH MHSA CSS requirements
500						Ability to generate staffing level reports by facility
501						Ability to generate caseload reports by clinician
502						Ability to generate caseload reports by facility or site

**Functional Requirements Matrix
Section VI - Billing**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Billing							
Billing - General							
503	Provides multi-site billing with centralized billing office model						
504	Provides multi-site billing with de-centralized billing office model						
505	Integrates or interfaces with registration, appointment scheduling, clinical EHR, authorizations, and eligibility components						
506	Ability to use multiple fee schedules in billing process						
507	Provides fee schedule update capability at the individual fee code level						
508	Provides global update of fee schedules						
	Ability to upload reference tables, including:						
509	CPT-4						
510	CPT-4 Modifiers						
511	DSM-IV						
512	ICD-9						
513	HCPCS						
514	Revenue codes						
515	Place of service codes						
516	Ability to manually modify reference tables						
517	Ability to establish User defined billing rules						
518	Ability to bill using sliding fee schedules						
519	Incorporates Medi-Cal regulations into billing Component						
520	Tracks Medi-Cal Share of Cost history						
521	Provides annual liability calculations and tracks limits						
522	Incorporates Medicare regulations into billing Component						
523	Tracks User, date and time of any additions, changes or deletions of billing related transactions						
	Ability to manage multiple reimbursement methodologies, including:						
524	Fee-for-Service						
525	Case rates						
526	Per diem						

**Functional Requirements Matrix
Section VI - Billing**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software

E=Not available

Requirement		A	B	C	D	E	Comments
527	Capitation						
528	Fixed rates						
529	Grant-in-aid						
530	Bundling and unbundling of service codes by payer						
531	Self-pay						
532	Sliding fee schedule						
533	Handles sequential billing of payers, ensuring that the sequence is based on coverage the client has and the services that are covered by the plans						
534	Ability to bill for a single client who has multiple distinct episodes						
535	Ability to bill multiple clients to a single guarantor						
Service Entry / Charge Capture							
536	Provides manual, batch-based charge entry with drop down menus						
537	Ability to bill administrative and educational services that are not related to a specific client						
538	Ability to record and bill Medi-Cal Administrative Activities (MAA)						
539	Ability to record and bill Medi-Cal Quality Assurance activities (QA)						
540	Ability to record and bill Community Outreach Services (COS)						
541	Generate services and charges based on progress note documentation						
542	Offers coding assistance to providers based on client record documentation						
543	Links appointment tracking number to charges for reconciliation purposes						
544	Ability to edit charges						
545	Ability to record Medi-Cal Share of Cost obligation						
Charge Generation							
Ability to calculate charges based on:							
546	Time or duration of service						
547	Units of service by service codes						
548	Incident-to services						
549	Ability to split charges or prorate charges amongst clinicians						
Group Services							
550	Calculates fees for group service billing						

**Functional Requirements Matrix
Section VI - Billing**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement	A	B	C	D	E	Comments
Charge Review						
551 Provides a review stage and release option						
Provides automatic billing edits to validate:						
552 Clinician credentials appropriate to service rendered						
553 Clinician certification is appropriate to payer						
554 Checks time durations for validity						
555 Checks service location appropriate to service rendered						
556 Detects duplicate service entry						
Bill Submission / HIPAA Transactions						
External payers						
Ability to print and reprint the following billing forms:						
557 UB-04						
558 CMS 1500 (08 / 05)						
559 Provides electronic submission of claims in the ASC X12N 837I and 837P transaction formats						
Provides ability to submit ASC X12N 837I / P to transactions to any of the following:						
560 Claims processing module						
561 External payers						
562 Medi-Cal						
563 Medicare						
564 Ability to generate Medicare crossover billing transactions						
565 Ability to process Medicare crossover billing transactions						
566 Ability to bill services to the last payer to be billed in the sequence other than the client or guarantor						
Ability to suppress billing of:						
567 Clients						
568 Guarantors						
569 Ability to bill multiple funds for services not covered by other payers						
570 Ability to bill third party insurance carriers						
Self Pay						

**Functional Requirements Matrix
Section VI - Billing**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement	A	B	C	D	E	Comments
571 Ability to apply manual adjustments to outstanding balances						
572 Ability to apply manual adjustments to the annual liability limit						
573 Ability for end-user to apply special user-defined payment arrangements						
Client Statements						
574 Ability to design custom client statements						
575 Ability to use preprinted client statements						
576 Ability to print client statements on demand						
577 Ability to print client statements in user-defined groupings or cycles						
578 Ability to suppress printing of bill						
579 Ability to create user-defined messages for letter generation						
580 Ability for the User to view the statement in the same format as the client						
581 Ability to reprint previous statements						
Grant Billing						
582 Ability to setup grants as a funding source						
Payment / Adjustment / Denial / Refund Application						
583 Ability to receive and process an ASC X12N 835 transaction remittance file from multiple payers						
584 Provides automatic, line item posting of payments, adjustments and denials based on ASC X12N 835 remittance file						
585 Ability to manually post payments, adjustments and denials to a line item						
586 Provides automatic batch posting of payments						
Provides time of service posting of:						
587 Co-payments						
588 Share of Cost payments						
589 Annual liability payments						
590 Balance due payments						
591 Generates cash deposit reports for cash drawer reconciliation						
592 Automatically transfers balances from one payer to the next						
593 Automatically generates bill to next payer once payment is posted						
594 Provides refund management for overpaid claims or claims paid in error						

**Functional Requirements Matrix
Section VI - Billing**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Accounts Receivable / Collections Management							
595	Shows client transaction register real-time, on-line						
	Ability to view the client transaction register with multiple filtering options, including:						
596	By date						
597	By provider						
598	By location						
599	Ability to transmit account data to outside collection agency						
Reporting							
600	Tracks missing charges by comparing appointments to charges						
	Provides detailed and summary level accounts receivable aging reports sorted by:						
601	Payer						
602	Provider						
603	Provides detailed and summary level aged credit balance reports						
604	Provides management reports						
605	Provides reports of charges						
606	Provides reports of payments						
607	Provides reports of adjustments						
608	Provides reports of denials						
609	Ability to define report layouts and choose fields						
610	Ability to generate Medi-Cal cost report						
611	Ability to generate Medicare cost report						
612	Provides a report writer tool allowing the User to generate customized reports						

**Functional Requirements Matrix
Section VII - Closure**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Closure							
Discharge Planning and Management							
	Ability to create a client discharge summary containing the following data elements:						
613	Admission date						
614	Discharge date						
615	Reason for admission or presenting information						
616	Services received						
617	Client response to services or treatments						
618	Provides for collection of Axis I - Axis V DSM IV Diagnosis data						
619	Multiple diagnoses by Axis						
620	Designation of one diagnosis as "primary"						
621	Medications prescribed						
622	Disposition and recommendations						
623	Additional user-defined fields						
	Provides reporting on episode closures that includes the following data fields:						
624	Client name						
625	Discharge date						
626	Referral out code						
627	Referring provider						
628	Legal status						
629	Diagnoses						
630	Additional user-defined fields						
631	Ability to re-open a closed episode when client returns for services						
632	Ability to modify a discharge date						
	Provides user-defined fields to enter clinical review notes on discharge summary including:						
633	Continued treatment needs						
634	Educational needs						
635	Supervision needs						
636	Progress notes						

**Functional Requirements Matrix
Section VII - Closure**

Place the number "1" into the appropriate response column:

A=Currently available B=In development (available by 7/1/2010) C=Available via vendor modification D=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
637	Medications						
	Provides reporting capability to capture:						
638	Open episodes without service activities for 60, 90, 120 days						
639	Open client records without service activities for user-defined period of time						
640	Closed episodes with referral out						
641	Closed episodes with no referral to external entity						
642	Ability to write free text notes						
	Tracks notes linked to each client episode by a system supplied audit trail that includes:						
643	User name						
644	Date						
645	Time						
	Referral Out Tracking						
646	Ability to generate a referral form to link clients to approved treatment, recovery, and aftercare support services						
647	Ability to define standard reasons for referral for use on referral form						
648	Ability to record multiple referrals per client						
	Ability to capture all of the following data elements related to referring a client to another provider:						
649	Agency						
650	Program						
651	Contact person						
652	Client name						
653	Client ID						
654	Admit date						
655	Referral date						
656	User-defined reasons for referral						
657	Transfer from						
658	Transfer to						
659	Aftercare arrangements notes						
660	User-defined fields						

**Functional Requirements Matrix
Section VII - Closure**

Place the number "1" into the appropriate response column:

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E=Not available

Requirement		A	B	C	D	E	Comments
661	Ability to set alerts, triggers, or reports at the client record level for periodic follow-up on progress and treatment coordination						
Record Retention							
662	Ability to archive client records and maintain files within a user-defined period						
663	Ability to print selected portions of client record upon request						
664	Ability to record and track client record requests						
	Ability to extract archived files upon demand by:						
665	Year						
666	Client						
667	Provider						
668	Date range						
Episode Closure / Record Closure							
669	Ability to close client episodes						
670	Ability to note reason for closure through user-defined codes and descriptions						
671	Automatic notification of episode closure to Case Manager or Case Coordinator						

**Functional Requirements Matrix
Section VIII - Claims**

Place the number "1" into the appropriate response column:

A=Currently available **B**=In development (available by 7/1/2010) **C**=Available via vendor modification **D**=Available using Third Party Software
E=Not available

Requirement		A	B	C	D	E	Comments
Claims Administration							
Claim Structure							
	Ability to use and validate HIPAA compliant code sets, including:						
672	CPT-4						
673	CPT-4 Modifiers						
674	DSM-IV						
675	ICD-9						
676	HCPCS						
677	Revenue codes						
678	Place of service codes						
679	NDC						
680	Ability to maintain the procedure code master file including modifiers and descriptions						
681	Ability to maintain the diagnosis code master file including descriptions						
682	Ability to maintain code history in order to adjudicate claims and adjustments with service dates prior to code updates						
683	Ability to receive and process provider submitted ASC X12N 837 - Health Claims or Equivalent Encounter Information						
684	Ability to manually enter CMS-1500 claims						
685	Ability to manually enter UB-04 claims						
686	Provides a data structure with standard claim fields that allows for electronic receipt and upload of ASC X12N 837 format						
687	Provides separate modules for institutional and professional claims with screen formats that capture all data elements from the CMS-1500 and UB-04						
688	Ability to receive and process the UB-04 format						
689	Ability to perform on-line adjudication						
690	Provides automatic assignment of claim unique number and retains that number until adjudication process is completed						
691	Ability to track and match internal claim numbers with Medi-Cal claim numbers when 835 file is received from the State						
692	Ability to submit Medi-Cal claims real-time to the SDMH						
	Ability to create, configure and maintain the following:						
693	Claims adjudication rules						
694	Claims edits						

**Functional Requirements Matrix
Section VIII - Claims**

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Requirement		A	B	C	D	E	Comments
695	Provider contract specific edits						
696	Fee schedules						
697	Remittance Advice remark codes						
698	Claims adjustment reason codes and descriptions						
699	Claims denial codes and descriptions						
700	Claims suspend codes and descriptions						
701	Claims payment disposition codes and descriptions						
702	Ability to configure and maintain benefit tables						
703	Ability to use a group or vendor ID						
704	Ability to use the National Provider Identifier (NPI)						
705	Interfaces with the Eligibility module to verify client eligibility						
706	Eligibility data contains start and end dates for current and historical eligibility						
707	Interfaces with the Authorization module during claims processing						
	Provides logic to automatically match claim to open authorization based on:						
708	Procedure codes within a designated range of authorized procedures						
709	Down-coded or up-coded procedures						
710	Provider practicing within the same group as the authorized provider or under the same vendor ID						
711	Client name						
712	Client ID						
713	Type of service						
714	Date of service						
715	Interfaces with Provider modules and allows claims examiners to look-up provider information						
716	Provides automatic pricing of claim based on the provider's contracted fee schedule						
717	Provides logic to detect user-defined timely filing limits based on service date and claim receipt date						
718	Provides logic to detect Medi-Cal and SDMH allowable late codes and adjudicate the claim appropriately						
719	Ability to create user-defined rules for determining whether provider payment for unauthorized services will be pended or paid						
720	Maintains complete history of all changes to claims						

**Functional Requirements Matrix
Section VIII - Claims**

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E=Not available

Requirement		A	B	C	D	E	Comments
	Provides access to the following additional information from the claims screen during adjudication without losing data entered:						
721	Client eligibility						
722	Provider contract, affiliation and pricing						
723	Procedure auto-coding tools						
724	Diagnosis auto-coding tools						
725	Authorizations						
726	Claims history						
727	Claims history notes						
728	Ability to enter free text claim notes						
	Tracks claim notes linked to each individual claim by:						
729	User name						
730	Date						
731	Time						
732	Ability to initiate global change of claims when benefit plan changes are made						
733	Ability to update funding sources on a claim without resubmitting to a payor						
	Pricing						
734	Ability to use multiple contractor agreements						
735	Provides logic to price claims with services funded by multiple payers and differing benefit designs						
	Ability to price claims using multiple payers for a client and the ability to track for each payer:						
736	Benefit limits						
737	Deductibles						
738	Co-pay						
739	Co-insurance						
740	Ability to track covered and non-covered services						
	Ability to price claims using multiple provider reimbursement rate methodologies including:						
741	Fee-for-Service						
742	Case rates						
743	Per diem						
744	Capitation						

**Functional Requirements Matrix
Section VIII - Claims**

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Requirement		A	B	C	D	E	Comments
745	Fixed rates						
746	Grant-in-aid						
747	Bundling and unbundling of service codes by payer						
748	Self-pay						
749	Sliding fee schedule						
750	Ability to price claims using multiple fee schedules by payer, including state-specific fee schedules						
751	Ability to price claims according to one-time negotiated fee arrangements						
	Payment and Adjudication						
752	Provides auto-adjudication of claims						
753	Automatically adjudicates claims on a per claim basis						
	Adjudicates claims based on:						
754	User-defined rules						
755	Payer eligibility						
756	Service included within benefit plan						
757	Provider eligibility						
758	Covered diagnoses						
759	Primary payer						
760	Secondary or other subsequent payer						
761	Other user-defined fund source rules						
762	Ability to initiate provisional payments for claims						
763	Calculates payment based on credit or debit balances						
764	Provides accounts payable function						
765	Maintains individual accounts for each provider						
766	Ability to link multiple facilities to a single administrative entity for payment						
767	Maintains transaction history of provider payment activity						
768	Provides accounts receivable function						
769	Ability to reconcile payments to receivables						
770	Ability to post cost settlement actions to provider balances						
771	Ability to apply refund checks to provider accounts						
772	Provides line item adjudication with whole claim pricing						
773	Ability to enter payment and denial information from Coordination of Benefits (COB) payers where the County is not the primary payer						

**Functional Requirements Matrix
Section VIII - Claims**

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E=Not available

Requirement	A	B	C	D	E	Comments
774 Provides logic to require COB information prior to County payment of secondary or tertiary benefits						
Provides complete COB adjudication including:						
775 Ability to price at a secondary and tertiary level						
776 Ability to process claims attachments						
777 Provides direct interaction with the authorization management module to limit claims payment						
778 Ability to configure claims to pend for review based on user-defined criteria						
779 Ability to set a provider contract maximum limit for each funding source						
780 Ability to edit against provider contract maximum amounts by funding source						
Sets claims to "deny" status when:						
781 Authorization is required and a matching authorization cannot be found						
782 Client is not found in eligibility files						
783 Provider is not certified to perform service						
784 Provider is not found						
785 Provider contract maximum amount is exceeded						
786 Claim does not meet user-defined timely submission criteria						
787 Funding source amount is exceeded						
Provides auto-population and manual entry of the following information on a claim:						
788 Co-payments						
789 Deductibles						
790 Out-of-pocket maximums						
791 Share of Cost						
792 Annual liability						
793 Co-insurance						
794 Detects duplicate claims or possible duplicate claims						
795 Ability to flag claims as duplicates or possible duplicates						
Ability to track service limits for each type of authorization including:						
796 Number of visits or days						
797 Number of client service hours						
798 Number of clinician service hours						
799 Number of days or weeks						
800 Specific service codes						

**Functional Requirements Matrix
Section VIII - Claims**

Place the number "1" into the appropriate response column:

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E=Not available

Requirement		A	B	C	D	E	Comments
801	Service codes clusters						
802	Specific dollar limits						
803	Ability to automatically generate reminders to service providers when authorization limits have been reached or nearly reached						
804	Calculates interest based on user-defined parameters						
805	Calculates interest based on provider contract stipulations						
806	Ability to track provider claims appeals and denials from inception to resolution						
807	Provides individual work queues for claims processors and examiners						
808	Automatically routes claims to queues to the appropriate level of examiner						
809	Ability for staff to route claims to a specific work queue						
810	Permits claims overrides based on security levels and fields						
811	Applies Medi-Cal lock-out rules when adjudicating claims						
Adjustment Processing							
812	Links adjustments (e.g., voids and additional payments) of claims to original claim						
813	Ability to adjudicate adjustment claims						
814	Ability to void claims						
815	Ability to suspend certain lines within a claim for research or additional documentation						
816	Ability to produce refunds to clients						
817	Ability to apply adjustments to provider credit and debit balances						
818	Maintains original claim number in subsequent claims (e.g., adjustments and voids)						
819	Provides real-time on-line correction process for pending claims						
Auditing and Validation							
820	Provides a batch control system to ensure all claims received are processed						
821	Validates each service performed by an identified staff person						
822	Checks services to determine valid time durations and location of service						
823	Checks services for duplicate service entry checks, with error notification at time of data entry						
Provides the following random sampling approaches for auditing:							
824	Percentage of claims						
825	By provider						
826	By client						
827	By examiner						
828	By status (e.g., processed, pending, adjudicated, paid)						

**Functional Requirements Matrix
Section VIII - Claims**

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Requirement		A	B	C	D	E	Comments
829	By dollar thresholds						
830	By specified date						
831	Provides flagging of claims by category for mandatory auditing						
832	Flags audited claims to avoid inclusion in subsequent audits						
833	Provides audit sampling for both prepayment and post payment timeframes						
	Reporting						
	Provides appropriate operations reports to support claims receipt and processing including:						
834	Pre-adjudicated batch reports						
835	Exception reports						
836	Claims ready for payment reports						
837	Claims aging reports						
838	Denied claims reports						
839	Pending claims reports						
840	Claims inventory report						
841	Account balance reports						
842	Ability to create user-defined reports						
843	Generates electronic and hard copy reports using the ASC X12N 835 - Healthcare Payment and Remittance Advice format						
844	Ability to create or suppress an Explanation of Benefits (EOB) / remittance advice based on user-defined criteria						
845	Ability to regenerate an EOB / Remittance Advice on demand						
846	Ability to print informational messages on EOB / Remittance Advice						
	Provides claims inquiry by:						
847	Provider, provider group or vendor ID						
848	Place of service						
849	Provider type						
850	Client, using all client search criteria						
851	Date of service or range of dates						
852	Date of receipt or range of dates						
853	Date of payment or range of dates						
854	Procedure						
855	Diagnosis						

**Functional Requirements Matrix
Section VIII - Claims**

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Requirement		A	B	C	D	E	Comments
856	Claims status (e.g., paid, pended, denied)						
857	NPI						
858	Combination of any of the above						
859	Provides reports of provider account balances						
860	Provides account receivable reports						
861	Provides account payables reports						
	Fee Schedule Maintenance						
862	Ability to manually update fee schedules						
863	Ability to maintain multiple fee schedules with start and end dates and retain history						
864	Retains historic fee schedules						
865	Applies appropriate fee schedule rates based on dates of service and fee schedule date during claims adjudication						
	Provider Data						
	Provider file contains the following key data elements:						
866	Unique provider ID						
867	Provider name						
868	National Provider Identifier (NPI)						
869	Provider IDs for all clinicians performing services at site						
870	Professional license number						
871	Driver's license number						
872	DEA Number						
873	Multiple provider addresses						
874	Status indicator						
875	Contract rates						
876	Contract maximums						
877	Funding source maximums						
878	Provider type						
879	Provider specialty						
880	Provider status						
881	Multiple provider site information						
882	Credentialing indicator						
883	Contact names						
884	User-defined fields						

**Functional Requirements Matrix
Section VIII - Claims**

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Requirement		A	B	C	D	E	Comments
885	Languages spoken						
886	Effective dates						
887	Certification indicators						
888	Certification dates						
889	Ability to inactivate providers and vendors						
890	Ability to retain inactive provider and vendor data						
	Ability to search provider file by:						
891	Provider ID						
892	Provider name						
893	Provider type						
894	Provider specialty						
895	Provider status						
896	NPI						
897	Ability to place a payment hold on providers and vendors						
898	Ability to update provider information						
899	Ability to add out of network providers						
900	Ability to print provider directory						
901	Ability to reactivate providers						
902	Ability to add providers manually						
903	Ability to upload provider data from external sources						
904	Ability to extract provider data to file						
905	Ability to store multiple contract rates for a single provider						
906	Ability to maintain historical contract rate information						
907	Ability to generate reports from the provider file						
908	Ability to detect potential duplicate provider file records						

**Functional Requirements Matrix
Section IX - Portals**

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Requirement		A	B	C	D	E	Comments
Portals							
909	Provides a secure web-enabled provider portal						
910	Tracks all activity of individuals accessing data through the provider portal						
911	Ability to create user-defined screens for use in the provider portal						
912	Provides a secure web-enabled client portal						
913	Tracks all activity of individuals accessing data through the client portal						
914	Ability to create user-defined screens for use in the client portal						