

**The Ohio Department of Medicaid's Methodology for
Covered Families & Children (CFC),
Aged, Blind, or Disabled (ABD),
and Adult Extension (Group VIII)
Encounter Data Quality Measures**

Provider Agreement Effective July 1, 2014 through June 30, 2015

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Purpose

The purpose of the encounter data volume measures is to monitor each MCP's encounter data submissions to ensure that the data is complete and that the number of encounters, which are submitted monthly, meet minimum volume standards.

Volume measures are calculated quarterly, by service category.

Service category groupings are based on codes (i.e. CPT, HCPCS, ICD-9), which are specified under each specific service category.

When a claim line item is identified for a particular service category, the entire claim (i.e. all line items submitted on the claim) is included in that service category. Service counts are determined by unduplicating, by Managed Care Plan, Medicaid recipient ID and date of service (i.e. 'discharge date' for Inpatient).

Member Months

Member months are determined using the ODM recipient master file, based on the recipient's managed care plan enrollment for that member month.

Encounter Data Quality Volume Approaches

ABD Adult Approach

The ABD Adult Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on Ohio program experience and expectations. The minimum performance standards are based on 1.5 standard deviations below MCP regional average rates for a duration of four quarters, and exclude low and high outliers. This strategy takes into consideration the MCP performance baseline and potential seasonal effects.

ABD Child Approach

The ABD Child Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. As this is a new measure, encounter data volume will be evaluated using interim standards for dates of service from July 1, 2013 through June 30, 2015. Interim standards are set based on 4 standard deviations below the historical Fee-For-Service average rates for a duration of thirteen quarters.

CFC Approach

The CFC Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. The performance target is set based on Ohio program experience and expectations. The minimum performance standards are based on 1.5 standard deviations below MCP regional average rates for a duration of four quarters, and exclude low and high outliers. This strategy takes into consideration the MCP performance baseline and potential seasonal effects.

Group VIII Approach

The Group VIII Volume measure is an Ohio specific data quality measure and therefore, does not have applicable national benchmarks to assist standard setting. As this is a new measure for a population that has not previously had Medicaid experience, encounter data volume will be reporting only for SFY 2015 and used as a baseline to set performance standards for SFY 2016.

Inpatient Hospital

This measure calculates the utilization rate for general/acute inpatient services: the number of discharges per 1,000 member months. Newborn and mental health inpatient stays are excluded.

Acute inpatient hospital services are identified by the following Type of Bill codes: 11X, 12X, 41X, and 84X.

Inpatient Hospital - Exclusions	
Newborns exclusions	Mental Health and Chemical Dependency exclusions
ICD-9 V codes	ICD-9 Primary Diagnosis
V30 – V39 Liveborn infants	290 to 316 Mental Disorders

Numerator: Discharges X 1,000

Discharges = encounters unduplicated by recipient ID and last date of the inpatient stay.

Denominator: Member Months

Data Source: Institutional Encounters

Behavioral Health

This measure calculates the behavioral health utilization rate: behavioral health visits per 1,000 member months. Emergency department visits for behavioral health diagnoses are included in this measure.

A behavioral health visit is defined as an non-institutional behavioral health visit, an institutional outpatient behavioral health visit, or an institutional inpatient behavioral health stay. The encounters used to calculate the numerator are unduplicated by recipient ID and date of service.

Codes to Identify Behavioral Health Services	
CPT	ICD-9 Diagnosis and Procedure codes
90801 to 90899 Psychiatry	290 to 316 Mental Disorders
HCPCS	960 to 979 Poisoning w/ secondary Dx of alcohol/drug psychoses, dependence or abuse (291,292, 303 – 305, 535.3, 571.1)
	94.26, 94.27, 94.61 to 94.69 ECT, Alcohol/drug rehab & detox
T1015 w/ modifier U3 FQHC/Outpatient Health Facility	

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Emergency Department

This measure calculates an emergency department (ED) utilization rate: ED visits per 1,000 member months. It includes all encounters with the codes(s) specified below.

Codes to Identify Emergency Department Visits					
Institutional Encounters			Non-Institutional Encounters		
Type of Bill		UB Revenue Codes ¹	CPT Codes ²		Place of Service Code
13X, 43X	and	045x, 981	10040 - 69979, 99281 - 99288	and	23 (Emergency Room-hospital)

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Dental

This measure calculates the utilization rate for dental services: dental visits per 1,000 member months. Emergency department visits for dental related diagnoses are included in the Emergency Department measure and are not included in this measure.

Codes to Identify Dental Visits	
CPT	CDT
70300, 70310, 70320, 70350, 70355 Radiology	D0120– D9999
ICD-9 Procedure Codes	HCPCS
23.xx and 24.xx Teeth, gums, and alveoli	T1015 w/ modifier U2 OHF / FQHC
87.11, 87.12 Dental x-rays	
89.31, 93.55, 96.54, 97.22, 97.33 - 97.35 99.97 Other dental procedures	

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Vision

This measure calculates the utilization rate for vision services: vision visits per 1,000 member months. Emergency department visits for vision-related diagnoses are included in the Emergency Department measure and are not included in this measure. Codes for eyeglass frames and lenses, contact lenses, ocular prosthetics and other vision aids are not included in this measure.

Codes to Identify Vision Visits	
CPT	HCPCS
92002 to 92371, 92499 Ophthalmology	T1015 w/ modifier U7 OHF / FQHC
65091 to 68899 Surgery, Eye	S0620, S0621, S0625, S3000
ICD-9 Procedure Codes	ICD-9 Diagnosis Codes
08.xx to 16.xx Operations on the eye	V72.0
95.0x to 95.2x Ophthalmologic Dx and treatment	

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Primary & Specialist Care

This measure calculates a utilization rate for primary and specialist care services: visits per 1,000 member months. Included are all physician office, clinic and hospital outpatient evaluation and management services provided by general practice providers and specialists, and other ambulatory care such as pregnancy-related and family planning services.

Codes to Identify Primary & Specialist Care			
CPT		HCPCS	
99201 to 99215	Office/Other Outpatient Services	T1015 w/ modifier U1	OHF / FQHC
99241 to 99245	Office/Other Outpatient Consults	H1000 to H1005	At-risk pregnancy services
99301 to 99337	Nursing Facility, Domiciliary, Rest Home, Custodial Care	H1011	Family planning educational visit
		S0610 to S0612	Annual gynecological exams
99341 to 99350	Home Services	S9436, S9437,	Pregnancy related services
99381 to 99429	Preventive Medicine Services	S9444, S9447,	
99499	Other evaluation & mgt. services	S9452, S9470	
59425 to 59430	Antepartum & postpartum care	G0344	Preventive Medicine Services
		ICD-9 V codes	
		V20.2	Routine infant/child health check
		V70.0, V70.3	
		V70.5, V70.6	Other medical exams
		V70.8, V70.9	

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Pharmacy

This measure calculates utilization rate for drugs: prescriptions per 1,000 member months.

Numerator: Prescriptions X 1,000

Prescriptions = encounters unduplicated by managed care plan, recipient ID, date of service, and NDC code

Denominator: Member Months

Data Source: Pharmacy encounters

Durable Medical Equipment (DME) – Reporting Only

This measure calculates the Durable Medical Equipment (DME) utilization rate per 1,000 member months.

Codes to Identify Durable Medical Equipment (DME)	
CPT	
A4206 to A8004, A9040	XX001, XX002, XX004, X1422 to X1428
B4034 to B9999	Y0021 to Y0024
E0100 to E8002	Y0499, Y0500, Y2010 to Y2083
K0001 to K0898	
L0100 to L9999	Y2271, Y2845, Y4211
Q0036, Q0040, Q0046	Y9039 to Y9049
S5517, S5518, S5520, S5521	Y9101 to Y9190
T4521 to T5999	Z7038

Numerator: Services X 1,000

Services = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Deliveries – Reporting Only

This measure calculates the rate of deliveries per 1,000 member months.

Codes to Identify Deliveries	
ICD-9 Procedure codes	ICD-9 CM Diagnosis codes
72.x Forceps, vacuum, and breech delivery	V24.0 – Postpartum care and examination immediately after delivery
	V27.x – Outcome of Delivery
73.51 Manual rotation of fetal head	<i>Except for code 650, the following codes must have a 5th digit equal to 1 or 2 to be included:</i>
73.59 Other manually assisted delivery	
73.8 Operations on fetus to facilitate delivery	
73.9 Other operations assisting delivery	
74.x Cesarean section and removal of fetus	640-649 Complications mainly related to pregnancy
CPT	650-659 Normal delivery and other indications for care in pregnancy, labor and delivery
59400-59410 Vaginal Delivery, Antepartum and Postpartum Care	660-669 Complications occurring mainly during the course of labor and delivery
59510-59515 Cesarean Delivery	
59610-59622 Delivery after Previous Cesarean Delivery	
	670-676 Complications of the puerperium

Numerator: Deliveries X 1,000

Deliveries = encounters unduplicated by managed care plan, recipient ID and date of service

Denominator: Member Months of Females

Data Source: Institutional and non-institutional encounters

Incomplete Rendering Provider Data -

Measure: The percentage of rendering providers reported on encounters without individual-level Medicaid and/or Reporting provider numbers as identified in MITS.*

Numerator: The number of line-level procedures in the denominator that do not have individual-level Medicaid and/or Reporting provider numbers as identified in MITS associated with an NPI as submitted on the encounter.

Denominator: The number of line-level procedures reported on professional 837 EDI transactions and accepted in MITS, excluding the following categories of procedures:

Anesthesia CPT codes within the range:

00100-01999

Radiology CPT codes within the range:

70010-76499

Pathology and Laboratory CPT codes within the range:

80047-89398

Laboratory HCPCPs codes that begin with S or Q

Rendering Provider Information: Rendering provider information may be provided on an encounter at either the claim- or the line-level; or the encounter may be submitted with only one provider in the billing provider data element. The rendering provider information retained by ODJFS will be as follows:

1. If the rendering provider is submitted on the encounter at the line-level, the line-level rendering provider information is retained;
2. If the rendering provider is only submitted at the claim-level or partially on the line-level, the claim-level rendering provider information is retained for any line item without a rendering provider;
3. If only the billing provider is submitted at the claim-level, without any rendering provider, the claim-level billing provider information is retained for all of the line items.

Data Source: Encounter Data

NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers

Measure: The percentage of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions with an NPI provider number in the billing provider EDI data fields that do not have a Medicaid or Reporting Provider Number in MITS.*

Numerator: The number of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions submitted and accepted in MITS where the NPI submitted on the encounter is not associated with a Medicaid or Reporting Provider Number in MITS.

Denominator: The number of institutional (837 I), professional (837 P), and dental (837 D) EDI transactions submitted and accepted in MITS with dates of service during the quarter.

Data Source: Encounter Data

Rejected Encounters (Measure 1 and Measure 2)

The percentage of encounters submitted to ODM that are rejected.

Numerator: The number of encounters that are rejected (meet a Threshold error).

Denominator: The number of submitted encounters in MITS (including those with a Paid, Threshold, and Informational status). A separate denominator will be calculated for each of the following file types: EDI 837 I, EDI 837 P, EDI 837 D, and NCPDP D.0.

Data Source: Encounter Data

Measure 2 (only applies to MCPs that have had Medicaid membership for one year or less):

For MCPs with less than one year of operation within the program, results are calculated and performance is monitored monthly. The report period varies depending on when the MCP began participation. The first reporting month begins with the third month of enrollment. The report period only extends throughout the MCP's first year of operation within the program. Measure 2 will not be calculated for SFY 2015.

This measure (both 1 and 2) is calculated per MCP and includes all members serviced by the MCP.

Acceptance Rate (only applies to MCPs that have had Medicaid membership for one year or less)

The number of acceptable encounters submitted to ODM for the month.

Numerator: The number of acceptable encounters.

Denominator: MCP membership per 1,000 Member Months. A separate denominator will be calculated for each of the following file types: EDI 837 I, EDI 837 P, EDI 837 D, and NCPDP D.0.

Data Source: Encounter Data

Encounter Data Accuracy Studies (Measure 1 and Measure 2)

Purpose of Studies:

Measure 1: The purpose of this study is to assess whether the payments made to a Managed Care Plan (MCP) for the delivery of a newborn have corresponding delivery records and medical record documentation to substantiate the delivery payment.

Measure 2: The purpose of this study is to assess the accuracy and completeness of payment data submitted on the encounter claims. The study will compare payment data stored in the MCPs' claim systems with payment data submitted to and accepted by ODJFS.

Methods:

The studies will be conducted by the External Quality Review Organization during contract year 2015. The methods will be developed once the studies are initiated and the draft methods will be shared with the MCPs to obtain comment and input. The methods will be posted to the website once they are finalized.

Measure 1 will be calculated per MCP and include all CFC members serviced by the MCP, as applicable.

Measure 2 will be calculated per MCP and include all members serviced by the MCP (CFC and ABD membership, as applicable).