

**ODJFS Methods for
Encounter Data Quality Measures**

**For the Covered Families and Children (CFC) and
the Aged, Blind, or Disabled (ABD) Managed Care
Programs**

For the Provider Agreement effective through June 30, 2007

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Encounter Data Volume CFC Report Schedule

Report Period	Data Source: Estimated Encounter Data File Update	Quarterly Report: Estimated Issue Date	Contract Period
Qtr 3 & Qtr 4 2003, 2004, 2005, 2006 Qtr 1 2007	July 2007	August 2007	SFY 2007
Qtr 3 & Qtr 4 2003, 2004, 2005, 2006 Qtr 1, Qtr 2 2007	October 2007	November 2007	
Qtr 3 & Qtr 4 2003, 2004, 2005, 2006 Qtr 1 thru Qtr 3 2007	January 2008	February 2008	SFY 2008
Qtr 3 & Qtr 4 2003, 2004, 2005, 2006 Qtr 1 thru Qtr 4 2007	April 2008	May 2008	
Qtr 3 & Qtr 4 2003, 2004, 2005, 2006 Qtr 1 thru Qtr 4 2007, Qtr 1 2008	July 2008	August 2008	
Qtr 3 & Qtr 4 2003, 2004, 2005, 2006 Qtr 1 thru Qtr 4 2007, Qtr 1, Qtr 2 2008	October 2008	November 2008	

Qtr1 = January to March
Qtr2 = April to June
Qtr3 = July to September
Qtr4 = October to December

Encounter Data Volume ABD Report Schedule

Report Period	Data Source: Estimated Encounter Data File Update	Quarterly Report: Estimated Issue Date	Contract Period
Qtr 1 2007	July 2007	August 2007	SFY 2007
Qtr 1, Qtr 2 2007	October 2007	November 2007	
Qtr 1 thru Qtr 3 2007	January 2008	February 2008	SFY 2008
Qtr 1 thru Qtr 4 2007	April 2008	May 2008	
Qtr 1 thru Qtr 4 2007, Qtr 1 2008	July 2008	August 2008	
Qtr 1 thru Qtr 4 2007, Qtr 1, Qtr 2 2008	October 2008	November 2008	

Qtr1 = January to March
Qtr2 = April to June
Qtr3 = July to September
Qtr4 = October to December

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/chemical dependency inpatient stays are excluded.

Acute inpatient hospital services are identified by the following Type of Bill codes: 11X, 12X, 41X, 42X 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
	960 to 979 Poisoning w/ additional Dx of alcohol/drug psychoses, dependence, or abuse (291,292, 303 - 305)

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

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

Behavioral Health

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

A behavioral health service 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 or date of discharge.

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

Numerator: Services X 1,000

Services = encounters unduplicated by recipient ID and date of service/discharge

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

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	450-452, 459, 981	10040 - 69979, 99281 - 99288	and	23 (Emergency Room-hospital)

¹If UB Revenue Code = '000' or missing, and the CPT code = 99281-99288, the service is included in the measure.

²If CPT codes 99281-99288 are reported and an outpatient hospital claim w Revenue Code 456 is reported for the same date of service, the encounter is included in the Primary & Specialists Care service category.

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

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

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	
<u>CPT</u>	<u>CDT</u>
70300, 70310, 70320, 70350, 70355 Radiology	D0120– D9999
<u>ICD-9 Procedure Codes</u>	<u>HCPCS</u>
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

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

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	
ICD-9 Procedure Codes	
08.xx to 16.xx Operations on the eye	
95.0x to 95.2x Ophthalmologic Dx and treatment	

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

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

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 99333 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, S9444, S9447, S9452, S9470 Pregnancy related services
99381 to 99429 Preventive Medicine Services	
99499 Other evaluation & mgt. services	
59425 to 59430 Antepartum & postpartum care	
Urgent Care Services	ICD-9 V codes
99281 to 99288 when an outpatient hospital claim w Revenue Code 456 is reported for the same date of service	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

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

Ancillary Services

This measure calculates the ancillary services utilization rate: visits per 1,000 member months. Ancillary services are defined as those non-emergent physician, practitioner, laboratory, and radiology services, that are not included in the behavioral health, dental, vision, and primary & specialist care categories.

Codes to Identify Ancillary Services	
CPT	
10000 to 99999 Surgery, Radiology, Lab, Medicine Excluding codes identifying Emergency Department, Behavioral Health, Vision, and Primary & Specialist Care services	HCPCS
	G0001 to G9016 Lab, misc. services
	J0150 to J9999 Injections
	P3000 to P9615 Lab
	T1015 w/ modifier U4 Physical therapy, FQHC & OHF
	T1015 w/ modifier U5 Speech path./Aud, FQHC & OHF
ICD-9-CM Procedure Codes	
01.xx to 07.9x, 17.x to 99.9x Excluding those codes specified for Behavioral Health, Dental, and Vision services	T1015 w/ modifier U6 Podiatry, FQHC
	T1015 w/ modifier U8 Chiropractor, FQHC
	T1015 w/ modifier UA/UB Lab/x-ray, OHF

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

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

Pharmacy

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

Numerator: Prescriptions X 1,000

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

Denominator: Member Months

Data Source: Pharmacy encounters

Note: Encounter data volume measures are evaluated by managed care type (i.e. CFC and ABD membership), per MCP.

Encounter Data Omission Study

Purpose of Study:

The purpose of the Encounter Data Omission Study is to assess whether and to what extent the Managed Care Plans (MCPs) are under-reporting ambulatory encounters from Primary Care Providers to the Ohio Department of Job and Family Services.

This annual study will compare the medical records of members during the time of membership to the encounters submitted. Omission rates will be calculated per MCP (i.e., to include all counties serviced by the MCP).

Methods:

The study will be conducted by the External Quality Review Organization during contract year 2007. The methods will be developed once the study is 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.

Note: This measure will be calculated per MCP and include all members serviced by the MCP (CFC and ABD membership).

Incomplete Outpatient Hospital Data

The percentage of outpatient hospital line items with one of the revenue center codes listed below which contained a valid procedure (CPT/HCPCS) code.

Numerator: The number of outpatient hospital line items which contained one of the revenue center codes listed below and a valid procedure (CPT/HCPCS) code. If no revenue center code was provided, then the line item was set to contribute zero to the numerator.

Denominator: The number of outpatient hospital line items during the quarter which contained one of the revenue codes listed below or the revenue center code was missing or 0.

Data Source: Encounter Data

Report Period: January - March, 2007; April - June, 2007; July - September, 2007; October - December, 2007.

Revenue Codes Where a HCPCS Code is Required
260,261,269,280,289,
300,301,302,304,305,306,307,309,310,311,312,314,319,320,321, 322,323,324,329,330,331,332,333,335,339,340,341,342,349,350,351,352,359,360,361, 369,370,371,372,379,
400,401,402,403,404,409,410,412,413,419,420,421,422,423,424,429, 430,431,432,433,434,439,440,441,442,443,444,449,450,456, 459,460,469,470,471,472,479,480,481,482,483,489,490,499,
510,511,512,513,514,515,516,517,519,530,531,539,
610,611,612,614,615,616,618,619,
700,709,720,721,722,723,724,729,730,731,732,739,740,749,750,759,760,761,762, 769,790,799,
820,821,829,830,831,839,840,841,849,850,851,859,880,881,889,
900,909,911,914,915,916,918,919,920, 921,922,923,924,925,929,940,942,943,944,945,949,952
Revenue codes are from Appendix B of Ohio Administrative Code rule 5101:3-2-21 (Medicaid fee-for-service policies for outpatient hospital services).

Outpatient hospital encounters are selected using the ODJFS derived “claim form indicator” field.

Note: This measure will be calculated per MCP and include all members serviced by the MCP (CFC and ABD membership).

Incomplete Data for Last Menstrual Period

The percentage of recipients with a live birth during the state fiscal year (SFY) where a “valid” last menstrual period (LMP) date was given on at least one encounter.

Numerator: The number of births where a valid LMP date was provided.

Denominator: The number of live births during the SFY.

Data Source: Encounter Data

Report Period: January - December, 2007

Codes to Identify Live Births

<u>ICD-9-CM Diagnosis Codes</u>

- | |
|---|
| 650 - Normal Delivery |
| V27.0 - Single liveborn |
| V27.2 - Twins, both liveborn |
| V27.3 - Twins, one liveborn and one stillborn |
| V27.5 - Other multiple birth, all liveborn |
| V27.6 - Other multiple birth, some liveborn |

<u>ICD-9-CM Diagnosis Codes*</u>

- | |
|--|
| V30 - Single liveborn |
| V31 - Twin, mate liveborn |
| V32 - Twin, mate stillborn |
| V33 - Twin, unspecified |
| V34 - Other multiple, mates all liveborn |
| V35 - Other multiple, mates all stillborn |
| V36 - Other multiple, mates live and stillborn |
| V37 - Other multiple, unspecified |
| V39 - Unspecified |

* These codes must have a matching delivery encounter to be included.

The infant’s record contains (or is supposed to contain) the infant’s Medicaid identification number. Therefore, it is necessary to match these encounters against the delivery encounters to obtain the mother’s recipient identification number, which is used to obtain the LMP date. Listed below are the codes used to identify deliveries (these are the same codes used to reimburse the plans for deliveries as part of the delivery payment).
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Note: This measure will be calculated per MCP and include all members serviced by the MCP (CFC and ABD membership).

Codes Used to Identify Deliveries

ICD-9 Procedure Codes:

- 72.x Forceps, vacuum, and breech delivery
- 73.51 Manually assisted delivery; Manual rotation of fetal head
- 73.59 Manually assisted delivery; Other
- 74.0 Cesarean section and removal of fetus; Classical cesarean section
- 74.1 Cesarean section and removal of fetus; Low cervical cesarean section
- 74.2 Cesarean section and removal of fetus; Extraperitoneal cesarean section
- 74.4 Cesarean section and removal of fetus; Cesarean section of other specified type
- 74.99 Cesarean section of unspecified type

ICD-9 Diagnosis Codes:

- 650 Normal Delivery
- V27.0 Single liveborn
- V27.2 Twins, both liveborn
- V27.3 Twins, one liveborn and one stillborn
- V27.5 Other multiple birth, all liveborn
- V27.6 Other multiple birth, some liveborn

The following codes must have a 5th digit equal to 1 or 2:

- 640-648; Complications mainly related to pregnancy
- 651-659; Normal delivery and other indications for care in pregnancy, labor, and delivery
- 660-669; Complications occurring mainly during the course of labor and delivery
- 670-676; Complications of the puerperium.

CPT Codes:

- 59409 Vaginal delivery (with or without episiotomy and/or forceps)
- 59514 Cesarean delivery only
- 59612 Vaginal delivery only, after previous cesarean delivery (with or with our episiotomy and/or forceps)
- 59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery

Births are included in the denominator only if the provider type (from the ODJFS provider master file) is 01 (General Hospital), 15 (Birthing Center), 71 (Nurse Midwife) or the provider type is 20 (Physician, Ind.), 21 (Physician, Group), 22 (Osteopath, Ind.), 23 (Osteopath, Group) with a specialty code of 01 (General Practice) , 15 (Internal Medicine) , 16 (Pediatrics) , 51 (General Surgery) , 53 (OB/GYN-MD) , 60 (Emergency Medicine) , or 71 (OB/GYN-DO).

Methods for Matching Infants and Mothers Encounters

The infants and mothers encounters are matched using the following two methods:

1) Same last name, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay;

OR

2) Same address and zip code, same three digit submitter number, and the infant's admission date is within 14 days before or 14 days after the mother's delivery stay.

If a newborn encounter matches to more than one mother delivery encounter and, consequently, it is not possible to determine which mother the newborn is associated with, then the matched encounter will not be included in the denominator. However, it continues to be possible for the mother's encounter to be included in the denominator if the mother's encounter contains one of the following diagnosis codes:

650 - Normal Delivery

V27.0 - Single liveborn

V27.2 - Twins, both liveborn

V27.3 - Twins, one liveborn and one stillborn

V27.5 - Other multiple birth, all liveborn

V27.6 - Other multiple birth, some liveborn

The date of the last menstrual period is identified using the "Accident/Symptom Date" field from the NSF and the occurrence code and occurrence date fields from the UB-92 format. If an occurrence code value of "10" is found, then the LMP date is extracted from the occurrence date fields. If the LMP date is from 119 to 315 days before the date the recipient gave birth, then the LMP date is considered a valid date.

Rejected Encounters

The percentage of encounters submitted to ODJFS that are rejected.

Numerator: The number of encounters that are rejected.

Denominator: The number of submitted encounters. A separate denominator will be calculated for each of the following file formats: NSF, UB-92, and NCPDP.

Data Source: Encounter Data

Report Period: For MCPs with more than one year of operation within the program per table below:

Report Period Dates of Service	Quarterly Report & Notification of Noncompliance Issue Date
July 2006 - September 2006	October 2006
October 2006 - December 2006	January 2007
January 2007 - March 2007	April 2007
April 2007 - June 2007	July 2007

For MCPs with one year or less 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.

Note: This measure will be calculated per MCP and will include all members serviced by the MCP (CFC and ABD membership).

Acceptance Rate

The number of acceptable encounters submitted to ODJFS 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 formats: NSF, UB-92, and NCPDP.

Data Source: Encounter Data

Report Period: For MCPs with one year or less of operation within the program, results are calculated and performance is monitored monthly. The report period varies depending on when the MCP began participating in the program. 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.

Note: This measure will be calculated per MCP and will include all members serviced by the MCP (CFC and ABD membership).

Incomplete Birth Weight Data

The percentage of liveborn delivery inpatient encounters during the state fiscal year which contained a birth weight.

Numerator: The number of liveborn delivery inpatient encounters where a birthweight was provided.

Denominator: The number of liveborn delivery inpatient encounters during the SFY. For method for identifying liveborns, see method for calculating “Incomplete Data for Last Menstrual Period” outlined above.

Data Source: Encounter Data

Report Period: January - December, 2007

If a value of ‘88’ through ‘96’ is found on any of the five condition code fields on the UB-92 inpatient claim format, then the encounter will be considered to have a birthweight. The condition code fields are described in Items 24-30 of the “Inpatient Hospital, UB-92 Claim Form Instructions.”

Note: This measure will be calculated per MCP and will include CFC members only.

Encounter Data Accuracy Study

Purpose of Study:

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's 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 2007. 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.

Note: Both measures will be calculated per MCP. Measure 1 will include CFC membership only. Measure 2 will include both CFC and ABD membership.

Generic Provider Number Usage

The percentage of non-pharmacy encounters during the reporting period which contained the generic provider number of 9111115.

Numerator: The number of non-pharmacy encounters where the generic provider number was used in the field designating the provider who rendered the service.

Denominator: The number of non-pharmacy encounters during the quarter.

Data Source: Encounter Data

Report Period: January - March, 2007; April - June, 2007; July - September, 2007; October - December, 2007.

Note: This measure will be calculated per MCP and include all members serviced by the MCP (CFC and ABD membership).