

**Methods for Members with Special Health
Care Needs Performance Measures**

**Aged, Blind, or Disabled (ABD)
Program**

Provider Agreement Effective through Contract Period ending June 30, 2008

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Issued: January, 2008

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OVERVIEW

Methodology

The performance measures for *Members with Special Health Care Needs* include data for members who are enrolled in an ABD managed care plan (MCP) with case management spans in an ABD MCP, regardless of the region(s) for which the MCP contracts. Therefore, the measure is calculated on a statewide basis for the MCP.

The methods to identify members with the targeted conditions that ODJFS mandated for case management are mostly consistent (the exceptions are for behavioral health and asthma exclusions for emphysema and COPD) with the diagnostic criteria used in the *Methods for Clinical Performance Measures: Aged, Blind, or Disabled Program* for the following conditions:

- Asthma
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Behavioral Health
- Substance Abuse
- Diabetes
- Non-Mild Hypertension
- Coronary Artery Disease

Data Sources

The sources of the data for calculating the measures is as follows:

- (1) MCP submitted encounter data.
- (2) Medicaid fee-for-service claims data.
- (2) ODJFS' Recipient Master File.
- (3) Case management data submitted and accepted in the Case Management System (CAMS).

Submission to the Case Management System (CAMS)

Appendix G, 3.b.iii.c.7 of the SFY 2008 Provider Agreement describes the required components of case management.

Report Periods

July – September 2007
October – December 2007
January – March 2008
April – June 2008

Identification of MSHCN for ODJFS Mandated Conditions

ODJFS uses a combination of encounter data and Medicaid fee-for-service (FFS) claims to identify MSHCN with the ODJFS-mandated conditions. For identifying members with ODJFS-mandated conditions, ODJFS includes all encounters submitted by the MCP and accepted into ODJFS' Encounter Data Master File with dates of service within the year prior to the report period. In addition, ODJFS includes Medicaid FFS claims data with dates of service within the year prior to the report period.

Medicaid FFS claims data is sent to MCPs on a monthly basis for all newly-enrolled members and on a weekly basis for continuing members. Both sets of files may include claims with dates of service within the prior two years. To identify MSHCN with the ODJFS-mandated conditions, ODJFS includes all data in Medicaid FFS claims files that have been transmitted to the MCP via SFTP up through the first week of the report period, with the exception of negative claims and positive claims that have been cancelled out (e.g., for the July through September 2007 report period, Medicaid FFS institutional and professional claims in files located in the CFC folder with drop-off dates from September 2006 through July 7, 2007 are included in identifying MSHCN with ODJFS-mandated conditions for the July through September 2007 report period, with exceptions as described below). The methodology for determining Medicaid FFS claims used to identify MSHCN with ODJFS-mandated conditions is as follows:

Institutional Files

- Include all claims (do not delete claims with reimbursement amounts of \$0)
- Distinguish positive and negative claims by Accounting Code:
 - Negatives: A, B, C, D, G, H, I, J
 - Positives: 0, E, F, K
- Delete all claims with a positive and negative match on the following fields (i.e., sort fields from positive and negative files in the following order):
 - Recipient ID
 - Provider (Data Element= 54)
 - Last Date of Service
 - First Date of Service
 - Reimbursement Amount
- Delete remaining negative claims by Accounting Code:
 - Negatives: A, B, C, D, G, H, I, J
- Only include final admit through discharge claims (no interim claims). 3rd Digit in Type of Bill = '1'
- Delete claims with Accounting Code = D (may be either positive or negative)

Professional Files

- Include all claims (do not delete claims with reimbursement amounts of \$0)
- Distinguish positive and negative claims by Accounting Code:
 - Negatives: A, B, C, D, G, H, I, J
 - Positives: 0, E, F, K
- Delete all claims with a positive and negative match (reimbursement amount) on the following fields (i.e., sort fields from positive and negative files in the following order):
 - Recipient ID
 - Provider (Data Element = 14)
 - Last DOS
 - Reimbursement Amount
- Delete remaining negative claims by Accounting Code:
 - Negatives: A, B, C, D, G, H, I, J

Pharmaceutical Files

- Include all claims (do not delete claims with reimbursement amounts of \$0)
- Distinguish positive and negative claims by Accounting Code:
 - Negatives: A, B, C, D, I, J

- Positives: 0, E, F
- Delete all claims with a positive and negative match on the following fields (i.e., sort fields from positive and negative files in the following order):
 - Recipient ID
 - Pay To Provider (Data Element= 15)
 - Last Date of Service
 - Reimbursement Amount
- Delete remaining negative claims by Accounting Code:
 - Negatives: A, B, C, D, I, J

Code Table

Methods for selected measures will reference the following code table.

Table CLMS-1: List of Applicable Provider Types

Claims submitted by the following provider types will be used to identify members with specific diagnoses for the following measures, as applicable.	
01 – General Hospital	22 – Physician (DO), Individual
04 - Outpatient Health Facility	23 – Physician (DO), Group
05 – Rural Health Facility	50 – Comprehensive Clinic
12- Federally Qualified Health Center	52 – Public Health Dept. Clinic
20 – Physician (MD), Individual	53 – Clinic, Rehabilitation
21 – Physician (MD), Group	65- Clinical Nurse Specialist
	71 – Certified Nurse Midwife
	72 – Certified Nurse Practitioner
	84 – Ohio Department of Mental Health
	86 – Skilled Nursing Facility

The average monthly case management rate for members who have at least three months of consecutive enrollment in one MCP.

Numerator: Sum of the numerators used to calculate the monthly case management rates during the report period.

Denominator: Sum of the denominators used to calculate the monthly case management rates during the report period.

Monthly Case Management Rate:

Numerator: The number of members in the denominator who are in case management for at least 7 days during the reporting month.

Denominator: The sum of all members who had at least three months of consecutive enrollment in the MCP prior to the reporting month and enrollment during the reporting month.

Example

(Report Period: July- September):

	<u>Members Case Managed</u>	Total Number of Members (with at least 3 months of consecutive enrollment in the MCP)	Monthly CM Rate
July:	50	500	10.0%
August:	60	510	11.8%
September:	<u>65</u>	<u>525</u>	<u>12.4%</u>
	175	1,535	11.4%

Data Source: CAMS, ODJFS' Recipient Master File

**Case Management of Members with an ODJFS-Mandated Condition
Measure 1: Asthma**

Table ASM-1: Codes to Identify Asthma

ICD-9 Diagnosis Code	
493.xx	Asthma

Table ASM-2: Methods to Identify Members with Persistent Asthma

Members must meet one of the four criteria below.	
Group 1.	Member has at least one emergency department visits (Table ASM-3) with asthma as the principal diagnosis (Table ASM-1).
Group 2.	Member has at least one acute inpatient discharge (Table ASM-3) with asthma as the principal diagnosis (Table ASM-1).
Group 3.	Member has at least four outpatient asthma visits (Table ASM-3) with asthma as one of the listed diagnoses (Table ASM-1) and at least two asthma medication dispensing events.
Group 4.	Member has at least four asthma medication dispensing events (i.e., an asthma medication dispensed on four occasions). <ul style="list-style-type: none"> • A member with at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed will be excluded from the denominator unless the member also has at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier. • A member with at least four asthma medication dispensing events and a diagnosis of emphysema or COPD (Table ASM-4) in any setting will be excluded from the denominator unless the member is identified as an asthmatic in groups 1 through 3.

A list of NDC codes for the appropriate denominator (i.e., members with persistent asthma) asthma medications may be found at www.ncqa.org.

Table ASM-3: Codes to Identify Asthma Visit Type

Description	CPT	UB-92 Revenue Codes
Outpatient	99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99382-99386, 99392-99396, 99401-99404, 99411, 99412, 99420, 99429, 99499	51x, 520-523, 526-529, 57x-59x, 77x, 982, 983
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 72x, 987
Emergency department	99281-99285	45x, 981

Table ASM-4: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Emphysema	492.x, 506.4, 518.1, 518.2
COPD	491.2, 493.2, 496, 506.4

Measure 1: Asthma

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of asthma who have had at least three

consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for asthma on the last day the report period.

Denominator: Number of members who were: 1) identified through encounter data and/or FFS claims as having a diagnosis of persistent asthma (Table ASM-2) within the year prior to the report period; and 2) had at least three consecutive months of enrollment in the MCP during the report period.

Data Source: Encounter Data, ODJFS' Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data

Measure 2: Chronic Obstructive Pulmonary Disease (COPD)

Table COPD-1: Codes to Identify COPD

ICD-9 Diagnoses Codes

491.XX	Chronic bronchitis
492.X	Emphysema
496	Chronic airway obstruction, not elsewhere classified

Measure 2: COPD

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of chronic obstructive pulmonary disease who have had at least three consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for COPD on the last day of the report period.

Denominator: Number of members who were: 1) identified through encounter data and/or FFS claims as having a diagnosis of COPD (Table COPD-1) within the year prior to the report period as reported on claims submitted by the provider types listed in Table CLMS-1; and 2) had at least three consecutive months of enrollment in the MCP during the report period.

Data Source: Encounter Data, ODJFS' Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data

Measure 3: Congestive Heart Failure (CHF)

Table CHF-1: Codes to Identify Congestive Heart Failure

ICD-9 Diagnosis Codes	
428.xx	Heart failure
398.91	Rheumatic heart failure (congestive)

Measure 3: CHF

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of congestive heart failure who have had at least three consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for CHF on the last day of the report period.

Denominator: Number of members who were: 1) identified through encounter data and/or FFS claims as having a diagnosis of CHF (Table CHF-1) within the year prior to the report period as reported on claims submitted by the provider types listed in Table CLMS-1; and 2) had at least three consecutive months of enrollment in the MCP during the report period.

Data Source: Encounter Data, ODJFS' Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data

Measure 4: Behavioral Health

Table SMD-1: Diagnosis Codes to Identify Severe Mental Disability – Behavioral Health

ICD-9 Principal Diagnosis Codes	
293.xx	Transient mental disorders due to conditions classified elsewhere
294.xx	Persistent mental disorders due to conditions classified elsewhere
295.xx	Schizophrenic disorders
296.xx	Episodic mood disorders
297.x	Delusional disorders
298.x	Other nonorganic disorders
299.xx	Pervasive developmental disorders

Table SCDL-1: Code to Identify Severe Cognitive and/or Developmental Limitation – Behavioral Health

Category of Service Code	AND	Individual Information File (IIF)
42		Medicaid recipient id

Table AOD-1: Codes to Identify AOD – Behavioral Health

ICD-9 Diagnosis Codes	
291.xx	Alcohol induced mental disorders
292.xx	Drug induced mental disorders
303.xx	Alcohol dependence syndrome
304.xx	Drug dependence
305.0x	Alcohol abuse
305.2x-	Other drug abuse

305.9x	
535.3	Alcohol gastritis
571.1	Acute alcohol hepatitis

Table INP-1: Codes to Identify Acute Inpatient Discharges

UB-92 Type of Bill
11x, 12x, 41x, 42x, 84x

Table ED-1: Codes to Identify Emergency Department Visits

UB-92 Revenue 45x, 981	AND	UB-92 Type of Bill 13x
<i>OR</i>		
CPT 10040 – 69979	AND	POS 23
<i>OR</i>		
CPT 99281-99285		

Measure 4: Behavioral Health

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of behavioral health who have had at least three consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for behavioral health on the last day of the report period.

Denominator: Number of members who had: 1) at least three consecutive months of enrollment in the MCP during the report period and who were: 2) identified through encounter data and/or FFS claims as having a diagnosis of severe mental disability (Table SMD-1) within the year prior to the report period as reported on claims submitted by the provider types listed in Table CLMS-1; and/or 3) identified through FFS claims **and** one of the Individual Information Form (IIF) files as being served through the MRDD (Table SCDL-1) within the year prior to the report period; and/or 4) identified through encounter data and/or FFS claims as having at least one AOD-related acute inpatient admission or at least two AOD-related Emergency Department (ED) visits within the year prior to the report period (“AOD-related” includes AOD acute inpatient admissions or ED visits with an AOD diagnosis as any of the listed diagnoses on the encounter/claim). See table AOD-1 to identify AOD diagnosis codes. See tables IP-1 and ED-1 to identify acute inpatient admissions and ED visits.

**Note: Claims for Medicaid services provided by the Ohio Department of Alcohol and Drug Addictions Services will not be used in this measure.*

Data Source: Encounter Data, ODJFS’ Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data

Measure 5: Diabetes

Table DIAB-1: Codes to Identify Diabetes

ICD-9 Diagnosis Codes			
250.xx	Diabetes mellitus	366.41	Diabetic cataract
357.2	Polyneuropathy in diabetes	648.0	Diabetes mellitus
362.0	Diabetic retinopathy		

Table DIAB-2: Methods to Identify Diabetic Members

- **Two methods identify diabetic members.**
- **A member needs to be identified in only one method to be included in the measure.**

Method 1: Pharmacy

Members who were dispensed insulin or oral hypoglycemics/antihyperglycemics (drug list is available on the NCQA's website at www.ncqa.org).

- *A member who was dispensed insulin or oral hypoglycemics/antihyperglycemics and had a diagnosis of polycystic ovaries, gestational diabetes or steroid-induced diabetes (Table DIAB-4) in any setting will be excluded from the denominator unless the member is identified as a diabetic in Method 2.*

Method 2: Inpatient, Outpatient & Emergency Department visits*

Members who had:

- Two (2) visits with different dates of service in an outpatient or nonacute inpatient setting with a diagnosis of diabetes per table DIAB-1, **OR**
- One (1) visit in an acute inpatient or emergency department setting with a diagnosis of diabetes per table DIAB-1

Table DIAB-3: Codes to Identify Visit Type

Description	CPT	UB-92 Revenue Codes
Outpatient	92002-92014, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99384-99387, 99394-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	51x, 520-523, 526-529, 57x-59x, 77x, 82x-85x, 88x, 982, 983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	118, 128, 138, 148, 158, 19x, 55x, 66x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	10x, 110-114, 119, 120-124, 129, 130-134, 139, 140-144, 149, 150-154, 159, 16x, 20x-22x, 72x, 80x, 987
Emergency dept.	99281-99285	45x, 981

Table DIAB-4: Codes to Identify Exclusions

Description	ICD-9-CM Diagnosis
Polycystic Ovaries (256.4),	256.4
Steroid Induced Diabetes	251.8, 962.0
Gestational Diabetes	648.8

Measure 5: Diabetes

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of diabetes who have had at least

three consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for diabetes on the last day of the report period.

Denominator: Number of members who were: 1) identified through encounter data and/or FFS claims as diabetic (Table DIAB-2) within the year prior to the report period; and 2) had at least three consecutive months of enrollment in the MCP during the report period.

Data Source: Encounter Data, ODJFS' Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data

Measure 6: Hypertension (non-mild)

Table HYP-1: Codes to identify Hypertension (non-mild)

CPT Code	
362.11	Hypertensive retinopathy
401.0	Essential hypertension, malignant
402.xx	Hypertensive heart disease
403.xx	Hypertensive kidney disease
404.xx	Hypertensive heart and kidney disease
437.2	Hypertensive encephalopathy

Measure 6: Hypertension (non-Mild)

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of non-mild hypertension who have had at least three consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for non-mild hypertension on the last day of the report period.

Denominator: Number of members who were: 1) identified through encounter data and/or FFS claims as having a diagnosis of non-mild hypertension (Table HYP-1) within the year prior to the report period as reported on claims submitted by the provider types listed in Table CLMS-1; and 2) had at least three consecutive months of enrollment in the MCP during the report period.

Data Source: Encounter Data, ODJFS' Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data

Measure 7: Coronary Artery Disease

Table CAD-1: Codes to Identify Coronary Artery Disease

ICD-9 Diagnosis Codes	
410.xx	Acute Myocardial Infarction
411.xx	Other acute/subacute forms of ischemic heart disease
412.xx	Old myocardial infarction

413.x	Angina pectoris
414.0x	Coronary atherosclerosis
414.8	Other specified forms of ischemic heart disease
414.9	Chronic ischemic heart disease, unspecified
429.2	Cardiovascular disease, unspecified
996.03	Mechanical complication of cardiac device/coronary bypass graft
V45.81	Aortocoronary bypass status

Measure 7: Coronary Artery Disease (CAD)

The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of coronary artery disease who have had at least three consecutive months of enrollment in one MCP that are case managed.

Numerator: Number of members in the denominator who are receiving case management services for non-mild hypertension on the last day of the report period.

Denominator: Number of members who were: 1) identified through encounter data and/or FFS claims as having a diagnosis of CAD (Table CAD-1) within the year prior to the report period as reported on claims submitted by the provider types listed in Table CLMS-1; and 2) had at least three consecutive months of enrollment in the MCP during the report period.

Data Source: Encounter Data, ODJFS' Recipient Master File, Medicaid Fee-for-Service Claims Data, CAMS Data