

**ODJFS Methods for
Covered Families & Children (CFC)
and
Aged, Blind, Disabled (ABD)
Encounter Data Quality Measures**

Provider Agreement Effective through Contract Period ending June 30, 2008

**Contact: Amanda Harpster
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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 2 thru Qtr 4 2004, 2005, 2006 Qtr 1 2007	July 2007	August 2007	SFY 2008
Qtr 3, Qtr 4 2004, 2005, 2006 Qtr 1, Qtr 2 2007	October 2007	November 2007	
Qtr4 2004, 2005, 2006 Qtr 1 thru Qtr 3 2007	January 2008	February 2008	
2005, 2006 Qtr 1 thru Qtr 4 2007	April 2008	May 2008	
Qtr 2 thru Qtr 4 2005, 2006 Qtr 1 thru Qtr 4 2007, Qtr 1 2008	July 2008	August 2008	SFY 2009
Qtr 3, Qtr 4 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 2008
Qtr 1, Qtr 2 2007	October 2007	November 2007	
Qtr 1 thru Qtr 3 2007	January 2008	February 2008	
Qtr 1 thru Qtr 4 2007	April 2008	May 2008	
Qtr 1 thru Qtr 4 2007, Qtr 1 2008	July 2008	August 2008	SFY 2009
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 Methods SFY 2008

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. For all services except Inpatient and Pharmacy claims are grouped, sequentially, according to the following hierarchy:

- i. Behavioral Health
- ii. Emergency Department
- iii. Dental
- iv. Vision
- v. Primary & Specialist Care
- vi. Ancillary Services

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 Medicaid recipient ID and last date of service (i.e. 'discharge date' for Inpatient).

Member Months

Member months are determined using the ODJFS recipient master file, based on the recipient's managed care plan enrollment and county of residence for that member month.

Encounter Data Quality Volume Approaches

ABD Interim Statewide Approach

Prior to the transition to the regional-based approach, encounter data volume will be evaluated by MCP, statewide, using an interim approach. Interim ABD standards are based on the CFC county-based standards.

ABD Statewide Approach

Transition to the statewide approach will occur after the first four quarters (i.e., full calendar year quarters) of statewide ABD membership. Encounter data volume will be evaluated by MCP, statewide, after determination of the data quality standards. The first four quarters of data (i.e., full calendar year quarters) from all MCPs serving in ABD programs membership will be used to determine standards.

CFC County-Based Approach

All counties with managed care membership as of January 1, 2006 will be included in a county-based measure until regional evaluation is implemented.

CFC Interim Regional-Based Approach

Prior to the transition to the regional-based approach, encounter data volume will be evaluated by MCP, by region, using an interim approach. Interim standards for each region are based on the CFC county-based standards. Interim Regional-based results are reported for the quarter only if the MCP had at least two months of enrollment with 1,000 members in each of the two months in the region. Note: A county, which is in an active region, with managed care membership as of January 1, 2006, will be included in both the County-Based and Interim Regional-Based approach until the Regional-Based approach is implemented.

CFC Regional-Based Approach

Transition to the regional-based approach will occur by region, after the first four quarters (i.e., full calendar year quarters) of regional membership. Encounter data volume will be evaluated by MCP, by region, after determination of the regional-based data quality standards. The first four quarters of data (i.e., full calendar year quarters) from all MCPs serving in an active region will be used to determine standards for that region.

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
<u>ICD-9 V codes</u>	<u>ICD-9 Primary Diagnosis</u>
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

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

**Encounter Data Volume Methods
SFY 2008**

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 last date of service/discharge

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

***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	and	UB Revenue Codes ¹	CPT Codes ²	and	Place of Service Code
13X, 43X	and	450-452, 459, 981	10040 - 69979, 99281 - 99288	and	23 (Emergency Room-hospital)
¹ If UB Revenue Code = '000' or missing, and the CPT code = 99281-99288, the service is included in the measure.					
² If 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 last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

***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 last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

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

**Encounter Data Volume Methods
SFY 2008**

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	
<u>CPT</u>	<u>HCPCS</u>
92002 to 92371, 92499 Ophthalmology	T1015 w/ modifier U7 OHF / FQHC
65091 to 68899 Surgery, Eye	
<u>ICD-9 Procedure Codes</u>	
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 last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

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

**Encounter Data Volume Methods
SFY 2008**

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,	Pregnancy related services
99381 to 99429	Preventive Medicine Services	S9444, S9447,	
99499	Other evaluation & mgt. services	S9452, S9470	
59425 to 59430	Antepartum & postpartum care		
Urgent Care Services			
(99281 to 99288) or (10000 – 69999 with place of service = 23)	when an outpatient hospital claim with Revenue Code 456 is reported for same date of service	ICD-9 V codes	
		V20.2	Routine infant/child health check
		V70.0, V70.3	Other medical exams
		V70.5, V70.6	
		V70.8, V70.9	

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

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

**Encounter Data Volume Methods
SFY 2008**

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, Dental, 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 last date of service

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

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

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 A7509, A9040	XX001, XX002, XX004, X1422 to X1428
B4034 to B9999	Y0021 to Y0024
E0100 to E2101	Y0499, Y0500, Y2010 to Y2083
K0001 to K0501, K0529 to K0597	Y2076, Y2078, Y2079, Y2080
L0100 to L9999	Y2271, Y2845, Y4211
Q0036, Q0040, Q0046	Y9039 to Y9049
S5517, S5518, S5520, S5521	Y9101 to Y9190
T4521 to T4542	Z7038

Numerator: Services X 1,000

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

Denominator: Member Months

Data Source: Institutional and non-institutional encounters

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

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	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	
74.0 Classical cesarean section	
74.1 Low cervical cesarean section	640-648 Complications mainly related to pregnancy
74.2 Extraperitoneal cesarean section	650-659 Normal delivery and other indications for care in pregnancy, labor and delivery
74.4 Cesarean section of unspecified type	
	660-669 Complications occurring mainly during the course of labor and delivery
CPT	670-676 Complications of the puerperium
59409 Vaginal delivery (with or without episiotomy and/or forceps)	
59514 Cesarean delivery	
59612 Vaginal delivery only, after previous cesarean delivery (with or without episiotomy, and/or forceps)	
59620 Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	

Numerator: Deliveries X 1,000
 Deliveries = encounters unduplicated by recipient ID and last date of service

Denominator: Member Months
Data Source: Institutional and non-institutional encounters

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

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, 2008; April - June, 2008; July - September, 2008; October - December, 2008.

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.

***This measure will be calculated per MCP and include all members serviced by the MCP (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, 2008; April - June, 2008; July - September, 2008; October - December, 2008.

***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 calendar year (CY) where a “valid” last menstrual period (LMP) date was given on at least one encounter.

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

Denominator: The number of deliveries during the CY.

Data Source: Encounter Data

Report Period: January - December, 2008

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

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).

***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

Deliveries are included in the denominator only if the type of bill is listed as 111 or 131 AND 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).

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 (Measure 1 and Measure 2)

The percentage of encounters submitted to ODJFS that are rejected for the quarter.

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 tape formats: NSF, UB-92, and NCPDP.

Data Source: Encounter Data

Report Period: For MCPs with more than one year of operation (Measure 1) within the program per table below:

Report Period Dates of Service	Quarterly Report & Notification of Noncompliance Issue Date
April 2008 - June 2008	July 2008
July 2008 - September 2008	October 2008
October 2008 - December 2008	January 2009
January 2009 - March 2009	April 2009
April 2009 - June 2009	July 2009
July 2009 - September 2009	October 2009
October 2009 - December 2009	January 2010
January 2010 - March 2010	April 2010

For MCPs with less than one year of operation within the program (Measure 2), 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.

***This measure will be calculated per MCP and 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 tape formats: NSF, UB-92, and NCPDP.

Data Source: Encounter Data

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.

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

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.

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