

**The Ohio Department of Medicaid's Methodology for
MyCare Ohio Encounter Data Quality Measures**

Provider Agreement Effective July 1, 2019 through June 30, 2020

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Purpose

The purpose of the encounter data volume measures is to monitor each MCOP's encounter data submissions, 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 cost report service classification logic from ODM's Actuary (per Q2 2019 data dictionary logic). All volume measures are calculated at either the detail or header level, according to the methodology.

Measure Specification

Numerator: Count of unique patient visits/admissions/scripts by MyCare Plan, Medicaid recipient ID, and by Date of Service for each Category of Services (e.g. outpatient, inpatient, dental) and Program Types (i.e. Medicaid & Medicare). Only non-duplicative and last encounter claims are counted.

Denominator: Unique member count for each month of eligibility by MyCare Plan, Medicaid recipient ID, and by Date of Service for each Program Types.

Data Source: Medicaid Informational Technology System (MITS)

Encounter Data Quality Volume Approaches

The MyCare of Ohio 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. Each MCOP will have its own minimum performance standard that is distinct from each of the other plans for each category of service. The minimum performance standard for each MCOP for each category of service is based on a weighted formula derived from that MCOP's rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set a MCOP specific standard for that category of service. This approach takes into consideration the MCOP performance baseline and potential seasonal effects, as well as allowing for differences between MCOP's in enrollment size and business strategy.

Inpatient Hospital

This measure calculates the utilization rate for general/acute inpatient services: the number of admissions per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS15	Inpatient — Hospital	All CLAIM_TYPE = I OR (CLAIM_TYPE = L AND NOT BILL_PRVDR_TYPE = 86)	Admits per 1,000 MM
Medicare – Informational Only			
COS01	Inpatient — Hospital	All CLAIM_TYPE = I OR (CLAIM_TYPE = L AND NOT BILL_PRVDR_TYPE = 86)	Admits per 1,000 MM

Numerator: Admissions X 1,000

Admissions = 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.

A behavioral health visit is defined as a 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.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS22	Behavioral Health	CLAIM_TYPE = M AND (BILL_PRVDR_TYPE = 84,95 OR Proc = 90785, 90791-90792, 90801- 90899, 96101-96120, G0396-G0397, G0409-G0411, H0001-H0044, H0046- H2037, T1016, Z0802-Z0819)	Visits per 1,000 MM
Medicare – Informational Only			
COS08	Behavioral Health	CLAIM_TYPE = M AND (BILL_PRVDR_TYPE = 84,95 OR Proc = 90785, 90791-90792, 90801- 90899, 96101-96120, G0396-G0397, G0409-G0411, H0001-H0044, H0046- H2037, T1016, Z0802-Z0819)	Visits per 1,000 MM

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.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS26	Dental	(CLAIM_TYPE = D) OR (CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = DXXXX)	Visits per 1,000 MM

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.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS21	Vision	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 92002–92499, V0000–V2629, V2786- V2799, W2004–W2014, W2048, S0500-S0596	Visits per 1,000 MM
Medicare – Informational Only			
COS07	Vision	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 92002–92499, V0000–V2629, V2786- V2799, W2004–W2014, W2048, S0500-S0596	Visits per 1,000 MM

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.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS20	Physician Services	<p>(All CLAIM_TYPE = O AND Rev_Cd =976-979, 983, 985-986) OR CLAIM_TYPE M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 00100-69999, 90281-90749, 90901-90999, 91010-91299, 92502-92700, 92920-93998, 94002-94799, 95004-96100, 96121- 98938, 98940-99199, 99201-99499, 99605-99607</p> <p>HCPCS Codes: G0008-G0127, G0181-G0235, G0237-G0239, G0245-G0255, G0259- G0372, G0402-G0408, G0420-G0427, G0436-G0451, G0454-G0455, G9001-G9012, J0120-J9999, Q0103, Q0104, Q0138, S0220-S0302, S0601-S0613, S1040, S9083, W0703-W0731, X0701-X0799, X9331-X9335, X3960, X9360, Z5831, Z7210, Z7217, Z7225, Z7226</p>	Visits per 1,000 MM
Medicare – Informational Only			
COS06	Physician Services	<p>(All CLAIM_TYPE = O AND Rev_Cd =976-979, 983, 985-986) OR CLAIM_TYPE M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 00100-69999, 90281-90749, 90901-90999, 91010-91299, 92502-92700, 92920-93998, 94002-94799, 95004-96100, 96121- 98938, 98940-99199, 99201-99499, 99605-99607</p> <p>HCPCS Codes: G0008-G0127,G0181-G0235, G0237-G0239, G0245-G0255, G0259- G0372, G0402-G0408, G0420-G0427, G0436-G0451, G0454-G0455, G9001-G9012, J0120-J9999, Q0103, Q0104, Q0138, S0220-S0302, S0601-S0613, S1040, S9083, W0703-W0731, X0701-X0799, X9331-X9335, X3960, X9360, Z5831, Z7210, Z7217, Z7225, Z7226</p>	Visits per 1,000 MM

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.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS29	Pharmacy	CLAIM_TYPE = P	Scripts per 1,000 MM

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

MyCare Ohio Waiver Services

This measure calculates the MyCare Ohio Waiver Services utilization rate per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS31	Personal Care/ Home Care Attendant	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5125, S5130, S5135, T1019	Services per 1,000 MM
COS32	Home Delivered Meals	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5170	Services per 1,000 MM
COS33	Assisted Living	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T2031	Services per 1,000 MM
COS34	Adult Day Care	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = A0080, A0090, S5100–S5102, T2003	Services per 1,000 MM
COS36	Nursing Services (RN, LPN, & LVN)	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T1002–T1003	Services per 1,000 MM
COS37	Waiver Transportation	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = A0100, A0200, S0215	Services per 1,000 MM
COS38	Personal Emergency Response Systems	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5160–S5162	Services per 1,000 MM
COS39	Assistive Equipment / Home Modification	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = S5165, T2029, T1999	Services per 1,000 MM
COS40	Other Waiver Services	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = G0155, H0045, S5121, S9470, T2025, T2038	Services per 1,000 MM

Numerator: Services X 1,000

Services = encounters unduplicated by recipient ID and date of service

Denominator: Member Months

Data Source: Non-institutional encounters

Home Health

This measure calculates the home health utilization rate per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS23	Home Health & Private Duty Nursing	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 99500–99602, G0151–G0154, G0156– G0164, S5180-S5181, S5497-S5523, S9061, S9097, S9123-S9124, S9325-S9339, S9340- S9379, S9490-S9810, T1000–T1001, T1004– T1005, T1021–T1022	Visits per 1,000 MM

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: All MyCare Member Months for the Medicaid Encounter Rate

Data Source: Non-institutional encounters

Long Term Care (LTC)

This measure calculates the LTC utilization rate: long term care stays per 1,000 member months.

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS17	Nursing Facility Per Diem	(CLAIM_TYPE = L AND BILL_PRVDR_TYPE = 86) AND (Rev_Cd = 0101, 0110, 0120, 0130, 0140, 0150, 0160, 0169, 0170, 0180, 0183, 0185, 0189, 0190, 0220, 0658)	Visits per 1,000 MM
Medicare – Informational Only			
COS03	Nursing Facility Per Diem	(CLAIM_TYPE = L AND BILL_PRVDR_TYPE = 86) AND (Rev_Cd = 0101, 0110, 0120, 0130, 0140, 0150, 0160, 0169, 0170, 0180, 0183, 0185, 0189, 0190, 0220, 0658)	Visits per 1,000 MM
COS04	Nursing Facility Other	(CLAIM_TYPE = L AND BILL_PRVDR_TYPE = 86) AND NOT (Rev_Cd = 0101, 0110, 0120, 0130, 0140, 0150, 0160, 0169, 0170, 0180, 0183, 0185, 0189, 0190, 0220, 0658)	Visits per 1,000 MM
COS05	Hospice Room and Board	CLAIM_TYPE = M AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T2046	Visits per 1,000 MM

Numerator: Visits X 1,000

Visits = encounters unduplicated by recipient ID and date of service

Denominator: All MyCare Member Months for the Medicaid Encounter Rate
Opt-In Member Months for the Medicare Encounter Rate

Data Source: Institutional encounters

Outpatient

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

COS ID	COS Description	Service Classification Logic	Measurement
Medicaid			
COS16	Outpatient - Hospital	All CLAIM_TYPE = O AND NOT Rev_Cd =976–979, 983, 985–986	Visits per 1,000 MM
Medicare – Informational Only			
COS02	Outpatient - Hospital	All CLAIM_TYPE = O AND NOT Rev_Cd =976–979, 983, 985–986	Visits per 1,000 MM

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

Notes:

[1] Units should be reported for each program in which a claim is paid. A claim is considered ""crossover"" if one of the following occurs, otherwise the claim is considered ""non-crossover"":

- 1) The claim is classified as Nursing Facility or Inpatient Hospital and the Medicare paid amount associated with the claim is nonzero; or
- 2) There is a nonzero Medicare allowed amount associated with the claim.

[2] CLAIM_TYPE = I shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 011X or 012X.

[3] CLAIM_TYPE = L shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 021X-029X, 051X-059X, or 061X-069X.

[4] CLAIM_TYPE = O shall be applied to claims submitted on the 837-I file with facility type codes (CLM05-1) equal to 013X-019X, 031X-039X, 041X-049X, 071X-079X, 081X-089X, or 091X-099X.

[5] CLAIM_TYPE = M shall be applied to claims submitted on the 837-P file.

[6] CLAIM_TYPE = D shall be applied to claims submitted on the 837-D file.

[7] CLAIM_TYPE = P shall be applied to claims submitted on the NCPDP file.

NPI Provider Number Usage Without Medicaid/Reporting Provider Numbers

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*.

Dates: Date of Service on the line-level procedure, in the measurement period described in Appendix L of the MyCare of Ohio Provider Agreement.

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.

In order to be identified in MITS, a Provider NPI must match an NPI found in MITS' Provider Master File. Each managed care plan should ensure that rendering provider NPIs being submitted to MITS are in the Provider Master File. Managed care plans are encouraged to work with providers and with ODM's Provider Enrollment area to ensure accurate provider enrollment information in MITS.

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:

-70010-79999

-Pathology and Laboratory CPT codes within the range:

-80047-89398; also 36415, 36416, 36420,36425

-Laboratory HCPCPs codes that begin with S or Q; also 99001, G0103, G0123, G0431, G0434, P9604, G6030-G6058, G0477-G0438

All provider types are included in the denominator, even those for which a Rendering Provider NPI is not required to be submitted. If a Rendering Provider NPI is blank upon submission of an encounter to MITS, then as described in the process below, MITS will populate the Billing Provider NPI as the Rendering Provider NPI. If the Billing Provider NPI matches an NPI in MITS Provider Master File, then the Rendering Provider NPI will be considered in compliance for this measure.

*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 ODM 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

Incomplete Billing Provider Data

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.

For this measure, an individual encounter/claim is considered an EDI transaction.

Dates: Date of Service on the encounter/claim at the header level, in the measurement period described in Appendix L of the MyCare of Ohio Provider Agreement.

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.

In order to be identified in MITS, a Provider NPI must match an NPI found in MITS' Provider Master File. Each managed care plan should ensure that billing provider NPIs being submitted to MITS are in the Provider Master File. Managed care plans are encouraged to work with providers and with ODM's Provider Enrollment area to ensure accurate provider enrollment information in MITS.

Data Source: Encounter Data