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

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Purpose

The purpose of the encounter data volume measures is to monitor each MCP'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. 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 Managed Care Plan, Medicaid recipient ID, and by Date of Service for each Category of Services (e.g. outpatient, inpatient, dental) and Population Groups (i.e. ABD, CFC, and Group VIII). Only non-duplicative and last encounter claims are counted.

Denominator: Unique member count for each month of eligibility by Managed Care Plan, Medicaid recipient ID, and by Date of Service for each Population Groups.

Data Source: Medicaid Informational Technology System (MITS)

Encounter Data Quality Volume Approaches

The EDV 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 MCP 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 MCP for each category of service is based on a weighted formula derived from that MCP's rates for a duration of six quarters, using a multiplicative factor of the weighted formula to set MCP specific standard for that category of service. This approach takes into consideration the MCP performance baseline and potential seasonal effects, as well as allowing for differences between MCP'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. Newborn/delivery and mental health inpatient stays are excluded. Nursing Facility stays are also excluded for Medicaid Managed Care Encounter Data Volume Reports; this category is only included in the MyCare Ohio Encounter Data Volume report.

COS ID	COS Description	Service Classification Logic	Measurement
COS01	Inpatient — Medical/Surgical	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 001-532, 580-639, 650-724, 791-952 OR DRG_CD_27 [1] = 001–761, 789–794, 799–872, 901– 989)	Admits per 1,000 MM
Exclusions:			
COS02	Inpatient — Psychiatric/SA	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 740-776 OR DRG_CD_27 [1] = 876–897)	Visits per 1,000 MM
COS03	Inpatient — Delivery	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 540-542, 560 OR DRG_CD_27 [1] = 765–768, 774–776)	Deliveries per 1,000 MM
COS04	Inpatient — Well Newborn	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 640 OR DRG_CD_27 [1] = 795)	Deliveries per 1,000 MM
COS05	Inpatient — Delivery — Other	CLAIM_TYPE = I [4] AND (DRG_CD-31 [1] = 544-546, 561-566 OR DRG_CD_27 [1] = 769–770, 777–782)	Deliveries 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
COS02	Inpatient — Psychiatric/Substance Abuse	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 740-776 OR DRG_CD_27 [1] = 876–897)	Visits per 1,000 MM
COS13	Outpatient – Behavioral Health	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE = 01, 02 AND Rev_Cd = 671, 900, 904, 906-907, 911-916, 918-919, 1002 AND Modifier = HE AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS36	Other — Behavioral Health	CLAIM_TYPE = M [6] 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

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.

COS ID	COS Description	Service Classification Logic	Measurement
COS15	ER — Emergency Room	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 450-459	Visits per 1,000 MM
COS16	ER — Surgery	CLAIM_TYPE O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 360–379, 490–499, 720–729 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS17	ER — Ambulatory Surgery Center	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE = 46 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS18	ER — Cardiovascular	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 480–489, 730–749 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS19	ER — PT/OT/ST	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 420–449 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS20	ER — Clinic	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 510–519 AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS21	ER — Other	All remaining CLAIM_TYPE = O [7] AND (Rev_Cd not in 300–319, 320–359, 400–409, 610–619, 971, 972–974, 976–979, 983, 985–986) AND Rev_Cd = 450-459 somewhere else on the claim	Visits per 1,000 MM
COS22	ER — ER Professional	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 46 AND Proc = 99281–99288	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. Emergency department visits for dental related diagnoses are included in the Emergency Department measure and are not included in this measure.

COS ID	COS Description	Service Classification Logic	Measurement
COS39	Other — Dental	(CLAIM_TYPE = D [3]) OR (CLAIM_TYPE = M [6] 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. 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.

COS ID	COS Description	Service Classification Logic	Measurement
COS40	Other — Vision — Optometric	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 92002–92499, V0000–V2629, V2786-V2999, W2004–W2014, W2048, S0580	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
COS23	Professional — Surgery	(CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 10000–11971, 11975–11983, 12001–36299, 36400–58999, 59420, 59425, 59426, 60000–69999, X3960) OR (CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 11972–11974, 11984–12000, 36300–36399 AND Modifier = 80)	Visits per 1,000 MM
COS24	Professional — Anesthesia	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND (Any Proc with the following modifiers: AA, AD, QK, QS, QX, QY, QZ) OR (Proc = 00100–01999)	Visits per 1,000 MM
COS25	Professional — Obstetrics	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 59000–59414, 59430–59999	Visits per 1,000 MM
COS26	Professional — Office Visits/Consults	(CLAIM_TYPE = O [7] AND Rev_Cd = 985–986 AND Rev_Cd = 450-459 nowhere else on the claim) OR (CLAIM_TYPE = O [7] AND Rev_Cd = 985–986 AND Rev_Cd = 450-459 somewhere else on the claim) OR (CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc =99201–99215, 99241–99275,99499)	Visits per 1,000 MM
COS27	Professional — Inpatient Visits	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 99217–99239, 99291–99297, 99301–99313, 99356, 99357, 99431–99440, 99460–99465, 99468–99486, X9331-X9335, X9360	Visits per 1,000 MM
COS28	Professional — Periodic Exams	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 99381–99397, 99401–99429, S0610, S0612	Visits per 1,000 MM
COS29	Professional — Immunizations & Injection	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 90281–90749, 90780, 90781, 90799, J0120–J9999, G0008, G0009, G0010, Q0138, W0703–W0731, X0701–X0799	Visits per 1,000 MM
COS30	Professional — Physical Medicine	(CLAIM_TYPE = O [7] AND Rev_Cd =976–979 AND Rev_Cd = 450-459 nowhere else on the claim) OR (CLAIM_TYPE = O [7] AND Rev_Cd =976–979 AND Rev_Cd = 450-459 somewhere else on the claim) OR (CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 97010–97799, Q0103, Q0104, Z5831, Z7210, Z7217, Z7225, Z7226)	Visits per 1,000 MM
COS31	Professional — Professional Misc. Services	(CLAIM_TYPE = O [7] AND Rev_Cd =983 AND Rev_Cd = 450-459 nowhere else on the claim) OR (CLAIM_TYPE = O [7] AND Rev_Cd =983 AND Rev_Cd = 450-459 somewhere else on the claim) OR (CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = 90901–90999, 91010–91299, 92502–92700, 92920–93998, 94002–94799, 95004–97009, 97800-99199, 99315–99318, 99324–99340, S1040, S9083)	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
COS38	Pharmacy — Retail	CLAIM_TYPE = P [8]	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

Durable Medical Equipment (DME)

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

COS ID	COS Description	Service Classification Logic	Measurement
COS44	Other — Supplies & DME	CLAIM_TYPE = M [6] AND BILL_PRVDR_TYPE not = 84,95 AND Proc = A4190–A9999, B4034–B5200, B9000–B9999, E0000–E9999, K0001–K9999, L0000–L9999, T4525–T4528, T4533–T4535, T4541, V2630-V2785, XX001–XX010, Y2064, Y2067, Y9101, Y9102, Y9106, Y9107, Y9110-Y9120, Y9127, Y9131–Y9163, Y9165–Y9188, Z7007–Z7050	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

Deliveries – *Reporting Only*

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

COS ID	COS Description	Service Classification Logic	Measurement
COS03	Inpatient — Delivery	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 540-542, 560 OR DRG_CD_27 [1] = 765–768, 774–776)	Deliveries per 1,000 MM
COS04	Inpatient — Well Newborn	CLAIM_TYPE = I [4] AND (DRG_CD_31 [1] = 640 OR DRG_CD_27 [1] = 795)	Deliveries per 1,000 MM
COS05	Inpatient — Delivery — Other	CLAIM_TYPE = I [4] AND (DRG_CD-31 [1] = 544-546, 561-566 OR DRG_CD_27 [1] = 769–770, 777–782)	Deliveries per 1,000 MM

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 encounters

Outpatient

This measure calculates the rate of outpatient visits per 1,000 member months. It includes outpatient clinic, surgical center, and therapy type services received in an outpatient hospital setting, excluding emergency department visits and Behavioral Health outpatient hospital visits.

COS ID	COS Description	Service Classification Logic	Measurement
COS08	Outpatient — Surgery	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 360–379, 490–499, 720–729 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS09	Outpatient — Ambulatory Surgery Center	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE = 46 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS10	Outpatient — Cardiovascular	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 480–489, 730–749 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS11	Outpatient — PT/OT/ST	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND Rev_Cd = 420–449 AND Rev_Cd = 450-459 nowhere else on the claim	Visits per 1,000 MM
COS12	Outpatient — Clinic	CLAIM_TYPE = O [7] AND BILL_PRVDR_TYPE not = 46 AND (Rev_Cd = 510–519 AND Rev_Cd = 450-459 nowhere else on the claim) OR Rev_Cd = 520–529	Visits per 1,000 MM
COS14	Outpatient — Other	All remaining CLAIM_TYPE = O [7] AND Rev_Cd not in 300–319, 320–359, 400–409, 610–619, 971, 972–974, 976–979, 983, 985–986 AND Rev_Cd = 450-459 nowhere else on the claim	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] APR—DRG grouper 31 shall be applied to all inpatient claims. For situations where the claim could not be grouped due to outdated or invalid diagnosis code, MS—DRG grouper 27 may be applied.

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

[4] 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.

[5] 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.

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

[7] 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.

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

[9] Information on eligibility for Respite Services can be found at the following website: http://archrespite.org/respite-locator-service-state-information/167-ohio-info.

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 Medicaid Managed Care 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 pay to provider type code and 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 Medicaid Managed Care 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