Ohio | Department of Medicaid

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

Provider Agreement Effective July 1, 2024, through June 30, 2025

Please note that no dates have been established for taking compliance on metrics contained in this document. Taking compliance is in a To Be Determined (TBD) state until further notice.

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Encounter Data Quality Volume

The purpose of the encounter data volume measures is to monitor MyCare Ohio Plans (MCOP) encounter data submissions, ensure that the data is complete, and that the number of encounters meet minimum volume standards. Volume measures are calculated quarterly, by service category. Service category groupings are based on Behavioral Health categories pertinent to the Ohio MyCare Program. All volume measures are calculated at either the detail or header level, according to the methodology.

Numerator: Number of paid claims by the members enrolled into the MCOP, Medicaid recipient ID, and by Date of Service for each Category of Services and Population Group. Only non-duplicative and paid encounters are counted.

Denominator: Unique member count for each month of eligibility enrolled into the MCOP during the time of service, Medicaid recipient ID, and by Date of Service for each Population Groups.

Data Source: Ohio Medicaid Enterprise System (OMES)

Encounter Data Quality Volume Approaches

The encounter data volume 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.

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

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

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

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	(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 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	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	Services per 1,000 MM

		AND BILL_PRVDR_TYPE not = 84,95 AND Proc = T2031	
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	Services per 1,000 MM

		Proc = G0155, H0045, S5121, S9470, T2025, T2038	

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 encounter

Long Term Care (LTC)

This measure calculates the LTC utilization rate: LTC 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

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

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

Encounter 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.

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

National Provider Identifier (NPI) for Ordering, Referring, and Prescribing (ORP) Providers

The MCOP must require an ordering, referring, or prescribing provider's NPI on a claim for any service that requires an order, referral, or prescription. The NPI for ORP Providers measure is calculated to ensure these providers reported on encounters can be verified by ODM in compliance with 42 CFR 438.602 and 42 CFR 455.410. includes all members receiving services from the MCOP.

Measure: Percentage of EDI transactions with qualifying billing provider types and specialties with an NPI provider number in the ORP provider EDI data field that have a valid NPI (Applicable for the **MyCare – Medicaid encounter type only):**

Pay to Provider Type	Pay to Provider Type Number	Claims requiring ORP
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY	03	All
Other Accred Home Hlth Agency	16	All with provider specialty code 455, 453, 450, 161, 160, 456, 457, 452
Professional Medical Group	21	ORP NOT required when rendering provider is any of the following types: Physician/Osteopath Individual, Physician Assistant, Clinical Nurse Specialist Individual, Nurse Midwife Individual, or Nurse Practitioner Individual (PT 20,24,65,71,72)
Non-Agency Nurse - RN or LPN	38	All
Physical Therapist Individual	39	All
Speech Language Pathologist	40	All
Occup Therapist Individual	41	All
Audiologist Individual	43	All
Hospice	44	All
Certified OH Behavior Analyst	53	All
Mcare Certified Hm Hlth Agency	60	All

Anesthia Assistant Indiv	68	All
Pharmacy	70	All
Cert RN Anesthetist Individual	73	All
Durable Medical Equip Supplier	76	All
Independent Diag Testing Fac	79	All
Independent Laboratory	80	All
Portable X-Ray Supplier	81	All
Waivered Services Individual	55	All with provider specialty code 453, 454, 455, 450, 451
Psychiatric Hospital	02	All with provider specialty code 018 or 019
Non-Agency Home Care Attendant	26	All with provider specialty code 260
Non-Agency Personal Care Aide	25	All with provider specialty code 450 and 250
Wheelchair Van	83	All with provider specialty code 451, 480, 490, or 830
Waivered Services Organization	45	All with provider specialty code 454, 453, 490, 451, 450, 455, 456, 457, 740, 452
Hospital	01	All with provider specialty code 761, 822, 823, 830, 002, 006, 700, 762, 760, 001, 003, 004, 005, 820, 821, 824
Clinic	50	claims with any procedure code on tab 1; claims with a TC modifier AND any procedure code on tab 2
Nursing Facility	86	claims with any procedure code on tab 1; claims with a TC modifier AND any procedure code on tab 2
FQHC	12	claims with any procedure code on tab 3
OHIO DEPARTMENT OF MENTAL HEALTH PROVIDER	84	claims with procedure codes 86580, 36415, or 82075, or claims with 81025 with QW modifier

OMHAS CERTIFIED/LICENSED TREATMENT PROGRAM	95	claims with procedure codes 86580, 36415, or 82075, or claims with 81025 with QW modifier

Encounter Data Submission

Information concerning the proper submission of electronic data interchange (EDI) Post Adjudicated Claim Data Reporting (PACDR) encounter transactions may be obtained from the Ohio Department of Medicaid website. The website contains PACDR Encounter Data Companion Guides for the Managed Care 837 dental, professional and institutional transactions. Additional Companion Guides for EDI transactions that should be used in conjunction with encounters include the 277CA Claim Acknowledgement and the 824 Application Advice. The PACDR Encounter Data Companion Guides shall be used in conjunction with the X12 Implementation Guides for EDI transactions. PACDR Encounters will be submitted to the OMES.

Encounter Data Submission Procedure. The MCOP shall submit encounter data files to ODM per the specified schedule and within the allotted amount established in the Ohio Department of Medicaid's Methodology for MCOP Encounter Data Quality Measures document.

The MCOP shall submit a letter of certification with each encounter data file in accordance with federal guidelines.

The letter of certification shall be signed by the MCOP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCOP's CEO or CFO.

Duplicate Encounter Submissions

For this measure, a duplicate encounter will be an encounter that posts a duplicate edit shown below in the OMES during the processing of the encounter.

- 502 – duplicate line on same claim
- 519 – duplicate claim line (mem/dos/cpt(rev)/mod)
- 522 – duplicate claim line (prov/mem/dos/cpt(rev)/mod)
- 531 – duplicate mem/dos/service code/pay to/modifier
- 532 – duplicate mem/dos/service code/pay to/rendering phys/modifier
- 755 – hcpcs/ndc duplicate

Measure. A monthly percentage of the number of encounters that post a duplicate edit.

Measurement Period. TBD

Example. An encounter received by the OMES in August 2022 that posts a duplicate edit for an encounter received in March 2022 will be counted in the August 2022 percentage of duplicate

errors for the month of August.

Similarly, an encounter received by the OMES in August 2022 that posts a duplicate edit for an encounter received in July 2022 will also be counted in the August 2022 percentage of duplicate error for the month of August.

Data Quality Standard. The percentage of encounters posting a duplicate edit for any month of this contract.

Timeliness of Encounter Data Submission

ODM requires MCO-paid encounters to be received by the OMES within 7 calendar days from the date the claim received a paid or denied status in the MCEs claims processing system.

Measure. The percentage of the MCE's total monthly paid encounters that are received and accepted by the OMES within 7 calendar days from the date the claim received a paid or denied statue in the MCEs claims processing system.

Measurement Period. TBD

Data Quality Standard. MCEs will be considered in compliance if the percent of total monthly paid encounters received within the measure is greater than XXX%.

Encounter Data Accuracy Studies

The MCOP shall ensure collection and submission of accurate data to ODM. Failure to do so jeopardizes the MCOP's performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

This accuracy study will compare the accuracy and completeness of payment data stored in the MCOP's claims systems during the study period to payment data submitted to and accepted by ODM. Two levels of analysis will be conducted: one to evaluate encounter data completeness for which two rates will be calculated and one to evaluate payment data accuracy. Encounter data completeness and payment accuracy will be determined by aggregating data across claim types i.e., dental, institutional (inpatient, outpatient, and other), professional, and pharmacy. Encounter data completeness for all claim types will be evaluated at the detail level. Payment data accuracy for each claim type will be evaluated based on how encounters are processed — i.e., either paid at the detail level or at the header level. As such, evaluation of payment data accuracy will be as follows: Dental and professional payment comparisons will be at the detail level; Inpatient-institutional payment comparisons will be at the header level, while outpatient-institutional and other-institutional payment comparisons will be at the detail level; and pharmacy payment comparisons will be at the header level.

1) **Encounter Data Completeness (Level 1).**
    a. **Omission Encounter Rate.** The percentage of encounters in the MCOP's fully adjudicated claims file not present in the ODM encounter data files.

b. **Surplus Encounter Rate.** The percentage of encounters in the ODM encounter data files not present in the MCOP's fully adjudicated claims files.

2) **Payment Data Accuracy (Level 2).**
   a. **Payment Error Rate.** The percentage of matched encounters between the ODM encounter data files and the MCOP's fully adjudicated claims files where a payment amount discrepancy was identified.

1) **Measurement Period.** In order to provide timely feedback on the accuracy rate of encounters, the measurement period will be the most recent from when the measure is initiated. This measure is conducted annually.

2) **Data Quality Standard.**
   a. **For Level 1.** An omission encounter rate and a surplus encounter rate of no more than 10% at the line-level records.
   b. **For Level 2.** A payment error rate will be calculated but used only for informational purposes. This rate calculation will be used to guide a future standard.