Ohio | Department of Medicaid

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

Provider Agreement Effective July 1, 2023 through June 30, 2024

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 Ohio Medicaid Managed Care Organization (MCO) 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 Medicaid Managed Care 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 a MCO, Medicaid recipient ID, and by Date of Service for each Category of Services and Population Groups (i.e. ABD and CFC). Only non-duplicative and paid encounters are counted.

Denominator: Unique member count for each month of eligibility enrolled into a MCO 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. 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–	Visits per 1,000 MM

		90899, 96101-96120, G0396-G0397, G0409-G0411, H0001–H0044, H0046–H2037, T1016, Z0802–Z0819	

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

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

Outpatient

This measure calculates the rate of 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

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: 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 OMES*.

Dates: Date of Service on the line-level procedure

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 OMES associated with an NPI as submitted on the encounter.

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

Denominator: The number of line-level procedures reported on professional 837 EDI transactions and accepted in OMES, 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 OMES, then as described in the process below, OMES will populate the Billing Provider NPI as the Rendering Provider NPI. If the Billing Provider NPI matches an NPI in OMES 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) or professional (837 P) 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 OMES.

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

Dates: Date of Service on the encounter/claim at the header level

Numerator: The number of institutional (837 I) and professional (837 P) EDI transactions submitted and accepted in OMES where the NPI submitted on the encounter is not associated with a Medicaid or Reporting Provider Number in OMES.

Denominator: The number of institutional (837 I) and professional (837 P) EDI transactions submitted and accepted in OMES with dates of service during the quarter.

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

Data Source: Encounter Data

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

The MCO 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 Ohio Medicaid Manage Care Program.

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.

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
Anesthesia 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

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.

Claim Data Received by the OMES versus Encounter Data Received by the OMES

For this measure, an encounter will be checked against an original claim received by the OMES to be sure that service codes (HCPCS, CPT, etc.) remain the same on both the claim and the encounter.

Measure. There will be three quarterly quality measures for this metric.

- Missing service code data on the encounter that was on the original claim.
- Additional service code data on the encounter that was not on the original claim.
- Changed service code data on the encounter from what was on the original claim.

Measurement Period. Measurement periods will be quarterly. When this measure begins is **TBD**.

For the SFY 2024 contract, changed service code data will be checked on an ongoing basis and reported as needed. There will not be any compliance actions for this measure.

Data Quality Standard. The percentage of encounters that have missing or additional service code data from what was submitted on the original claim. The percentage for compliance is **TBD**.

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 MCO shall ensure collection and submission of accurate data to ODM. Failure to do so jeopardizes the MCO'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 MCO'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 MCO'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 MCO's fully adjudicated claims files.

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

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

4. **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 of no more than 4% for each claim type based on how encounters are processed—i.e., either paid at the detail level or at the header level.

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 MCO 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 Covered Families & Children (CFC), Aged, Blind, or Disabled (ABD), and Adult Extension (Group VIII) Encounter Data Quality Measures document.

The MCO 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 MCE'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 MCE's CEO or CFO.

Required Monthly Minimum Number of Encounters Accepted By the OMES

Measure. The monthly number of encounters ODM determines must be submitted and accepted by the OMES.

Measurement Period. TBD

Data Quality Standard. MCOs will be considered in compliance if the total number of encounters submitted and accepted into OMES meets or exceeds the number of encounters ODM determines each plan must submit on a monthly basis.