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

Provider Agreement Effective July 1, 2022 through June 30, 2023

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Encounter Data Quality Volume

The purpose of the encounter data volume measures is to monitor OhioRISE 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 Behavioral Health categories pertinent to the OhioRISE 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 OhioRISE Plan, 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 the OhioRISE plan during the time of service, 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.

July 2022 OhioRISE Rate Methodology and Data Book OhioRISE Included Services	
Service Grouping	**Service Identification Criteria**
1) Inpatient	Claims with Claim Type = 'I' that satisfy one or more of the following: 1) Billing Provider Type = '02' 2) Billing Provider Type not = '02' where DRG is in (740, 750-760, 770, 773-776)
2) PRTF	Claims with Billing Provider Type = '03'
3) Outpatient	Claims with Claim Type = 'O' that satisfy all of the following: 1) Revenue Code not = '045X' 2) HCPCS not in (Emergency Room HCPCS)[1]

	and that satisfy one or more of the following: 1) Billing Provider Type = '02' 2) HCPCS in (Outpatient HCPCS)[1] and primary diagnosis in (Outpatient Diagnosis)[1]
4) FQHC / RHC	Claims that satisfy one or more of the following: 1) A Billing Provider Type in ('12','05') with a procedure code of 'T1015' and a Modifier 'U3' 2) A Billing Provider Type in ('12','05') with a procedure code of 'T1015', a Modifier 'U1', and a primary SMI or SUD diagnosis[2]
5) Mental Health and Addiction Services Providers	Claims with a Billing Provider Type in ('84','95') or Rendering Provider Type in ('84','95')
6) BH Psychiatrists	Claims that satisfy all of the following: 1) Billing Provider Type in ('01', '02', '21', '50', '20') 2) Rendering Provider Type = '20' 3) Rendering Provider Specialty in ('213', '227', '234')
7) Other Licensed Providers	Claims that satisfy one or more of the following: 1) Rendering or Billing Provider Type = '37' and Provider Specialty = '370' 2) Rendering or Billing Provider Type = '42' and Provider Specialty in ('420', '421') 3) Rendering or Billing Provider Type = '47' and Provider Specialty = '474' 4) Rendering or Billing Provider Type = '52' and Provider Specialty = '520' 5) Rendering or Billing Provider Type = '54' and Provider Specialty = '540'

1. **Refer to Appendix B**
2. **Refer to Appendix A**

Numerator: Last adjudicated and paid claims with the Service Groupings

Denominator: OhioRISE Members

Rate: Ohio Rise Members with the Service Groupings per 1,000 Member Month

Data Source: Encounters

Measurement Period	Reporting Period	ABD/CFC Thresholds
July 2022 – September 2022	December 2022	TBD
October 2022 – December 2022	March 2023	TBD
January 2023 – March 2023	June 2023	TBD

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

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

Measurement Period	Reporting Period	Rendering Thresholds
July 2022 – September 2022	December 2022	Informational Only
October 2022 – December 2022	March 2023	Informational Only
January 2023 – March 2023	June 2023	Informational Only

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 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

Numerator: The number of institutional (837 I) and professional (837 P) 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) and professional (837 P) 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

Measurement Period	**Reporting Period**	**Billing Thresholds**
July 2022 – September 2022	December 2022	Informational Only
October 2022 – December 2022	March 2023	Informational Only
January 2023 – March 2023	June 2023	Informational Only

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

The MCP 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 OhioRISE 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.

Billing Provider Type Code	Billing Provider Type Name	ORP Criteria
84	Ohio Department of Mental Health Provider	Claims with Procedure Codes 86580, 36415, 82075, or 81025 with QW modifier
95	OMHAS Certified/Licensed Treatment Program	Claims with Procedure Codes 86580, 36415, 82075, or 81025 with QW modifier

Measurement Period	Reporting Period	Billing Thresholds
July 2022 – September 2022	December 2022	TBD
October 2022 – December 2022	March 2023	TBD
January 2023 – March 2023	June 2023	75%

Duplicate Encounter Submissions

For this measure, a duplicate encounter will be an encounter that posts edit XXXX in the Fiscal Intermediary (FI) during the processing of the encounter.

This quality measure and standard will be in a "to be determined (TBD) state until an appropriate data quality standard can be determined.

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

Measurement Period. For the SFY 2023 contract period, encounter data received on and after July 1, 2022 through June 30, 2023. This measurement is not based on date of service. Therefore, a duplicate edit that posts after July 1, 2022, for encounters that were received either before or after July 1, 2022, will be counted in that months percentage of encounters posting a duplicate edit.

Example. An encounter received by the FI 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 FI in August 2022 that posts a duplicate edit for an encounter received in July 2022 will also be counter in the August 2022 percentage of duplicate error for the month of August.

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

Claim Data Received by the FI versus Encounter Data Received by the FI

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

This quality measure and standard will be in a "to be determined (TBD)) state until an appropriate data quality standard can be determined.

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. For the SFY 2023 contract, only the missing and additional service code measures will be looked at for compliance. Measurement periods will be quarterly from July 2022 through June 2023 and will be based on the date the encounter is received by the FI.

For the SFY 2023 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.

Timeliness of Encounter Data Submission

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

This quality measure and standard will be in a "to be determined" (TBD) state until an appropriate data quality standard can be determined.

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

Measurement Period. For the SFY 2023 contract period, encounter data received on and after July 1, 2022 through June 30, 2023 for each month of the contract.

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 MCE shall ensure collection and submission of accurate data to ODM. Failure to do so jeopardizes the MCE'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 MCE'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**
    a. **Omission Encounter Rate**. The percentage of encounters in the MCE'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 MCE's fully adjudicated claims files

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.

Data Quality Standard:

1. An omission encounter rate and a surplus encounter rate of no more than 10% at the line-level records.
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) encounter transactions may be obtained from the Ohio Department of Medicaid (ODM) website. The website contains Encounter Data Companion Guides for the Managed Care 837 dental, professional and institutional transactions, and the NCPDP D.0 pharmacy transactions. Additional Companion Guides for transactions that should be used in conjunction with encounters include the U277 Unsolicited Claim/Encounter Status Notifications, the 824 Application Advice, and the TA1 Transmission Acknowledgement are also available on the website. The Encounter Data Companion Guides shall be used in conjunction with the X12 Implementation Guides for EDI transactions. Beginning June 2022, the MCE must follow the 837 Post-Adjudicated Claim Data Reporting (PACDR) standards for dental, professional, and institutional member encounter data submissions, including allowed amount and paid amount, per 42 CFR 438.242(c)(3). Encounters will be submitted to the Ohio Medicaid Enterprise System (OMES).

Encounter Data Submission Procedure. The MCE 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 MCP shall submit a letter of certification, using the form required by ODM, with each encounter data file in the ODM-specified medium per format.

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.