211.100 Episode Definition/Scope of Services

A. **Episode subtypes:**
   
   There are no subtypes for this episode type.

B. **Episode trigger:**

   A live birth on a facility claim

C. **Episode duration:**

   Episode begins 40 weeks prior to delivery and ends 60 days after delivery

D. **Episode services:**

   All medical assistance with a pregnancy-related ICD-9 diagnosis code is included. Medical assistance related to neonatal care is not included.

211.300 Exclusions

Episodes meeting one or more of the following criteria will be excluded:

A. Limited prenatal care (i.e., pregnancy-related claims) provided between start of episode and 60 days prior to delivery

B. Delivering provider did not provide any prenatal services

C. Episode has no professional claim for delivery

D. Pregnancy-related conditions: amniotic fluid embolism, obstetric blood clot embolism, placenta previa, severe preeclampsia, multiple gestation ≥3, late effect complications of pregnancy/childbirth, puerperal sepsis, suspected damage to fetus from viral disease in mother, cerebrovascular disorders

E. Comorbidities: cancer, cystic fibrosis, congenital cardiovascular disorders, DVT/pulmonary embolism, other phlebitis and thrombosis, end-stage renal disease, sickle cell, Type I diabetes

212.300 Exclusions

Episodes meeting one or more of the following criteria will be excluded:

A. Duration of less than 4 months

B. Small number of medical and/or pharmacy claims during the episode

C. Beneficiaries with any **comorbid** behavioral health condition or **developmental disability**

D. Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

213.100 Episode Definition/Scope of Services

A. **Episode subtypes:**

   There are no subtypes for this episode type.
B. **Episode trigger:**

Inpatient admission with a primary diagnosis code for heart failure

C. **Episode duration:**

Episodes begin at inpatient admission for heart failure. Episodes end at the latter of 30 days after the date of discharge for the triggering admission or the date of discharge for any inpatient readmission initiated within 30 days of the initial discharge. Episodes shall not exceed 45 days post-discharge from the triggering admission.

D. **Episode services:**

The episode will include all of the following services rendered within the episode’s duration:

1. Inpatient facility and professional fees for the initial hospitalization and for all cause readmissions *(excluding those defined by Bundled Payments for Care Improvement (BPCI))*
2. Emergency or observation care
3. Home health services
4. Skilled nursing facility care due to acute exacerbation of CHF (services not included in episode for patients with SNF care in 30 days prior to episode start)
5. Durable medical equipment

E. **Continuous Medicaid Enrollment**

For the purpose of the CHF episode, the beneficiary must be enrolled in Medicaid beginning at least 30 days before the start of the episode and maintain continuous enrollment in Medicaid for the duration of the episode.

---

214.100 **Episode Definition/Scope of Services**

A. **Episode subtypes:**

There are no subtypes for this episode type.

B. **Episode trigger:**

A surgical procedure for total hip replacement or total knee replacement

C. **Episode duration:**

Episodes begin 30 days prior to the date of admission for the inpatient hospitalization for the total joint replacement surgery and end 90 days after the date of discharge.

D. **Episode services:**

The following services are included in the episode:

1. From 30 days prior to the date of admission to the date of the surgery: All evaluation and management, hip- or knee-related radiology and all labs/imaging/other outpatient services
2. During the triggering procedure: all medical, inpatient and outpatient services
3. From the date of the surgery to 30 days after the date of discharge: All cause readmissions *(excluding those defined by Bundled Payments for Care Improvement (BPCI))* , non-traumatic revisions, complications, all follow-up evaluation & management, all emergency services, all home health and therapy, hip/knee radiology and all labs/imaging/other outpatient procedures
4. From 31 days to 90 days after the date of discharge: Readmissions *(excluding those defined by BPCI)* due to infections and complications as well as hip or knee-related
follow-up evaluation and management, home health and therapy and labs/imaging/other outpatient procedures

215.000  **OPPOSITIONAL DEFiant DISORDER (ODD) EPISODES**

215.100  **Episode Definition/Scope of Services**

A.  **Episode subtypes:**

There are no subtypes for this episode type.

B.  **Episode trigger:**

ODD episodes are triggered by three medical claims with a primary diagnosis of ODD.

C.  **Episode duration:**

The standard episode duration is a 90-day period beginning at the time of the first trigger claim. Claims for a beneficiary are tracked for 180 days following the closure of the 90-day standard episode to determine the episode remission rate quality metric.

D.  **Episode services:**

All claims with a primary diagnosis of ODD. Behavioral health medications will be excluded from the episode, but utilization of medications will be tracked as a quality metric for providers “to pass.”

Notwithstanding any other provisions in the provider manual, medical assistance included in an ODD episode shall not be subject to prior authorization requirements.

215.200  **Principal Accountable Provider**

Determination of the Principal Accountable Provider (PAP) is based upon which provider is responsible for the largest number of claims within the episode.

The provider responsible for the largest number of claims is designated the PAP. In instances in which two providers are responsible for an equal number of claims within the episode, the provider whose claims accounted for a greater proportion of total reimbursement will be designated PAP.

Providers eligible to be PAPs include primary care physicians, psychiatrists, clinical psychologists, and RSPMI provider organizations.

215.300  **Exclusions**

Episodes meeting one or more of the following criteria will be excluded:

A.  Beneficiaries not continuously enrolled in Medicaid during the 90-day episode

B.  Beneficiaries with any behavioral health comorbid condition

C.  Beneficiaries age 5 or younger and beneficiaries age 18 or older at the time of the initial claim

215.400  **Adjustments**

Only episodes with 10 or more visits over >30 days will be able to reduce a PAP’s average episode cost. PAPs with no episodes with 10 or more visits over >30 days in a performance period will not be eligible for gain sharing.

215.500  **Quality Measures**
Episodes of Care

Section II

A. Quality measures “to pass”:

1. Percentage of episodes with completion of either Continuing Care or Quality Assessment certification – must meet minimum threshold of 90% of episodes.

2. Percentage of new episodes (i.e., a PAP’s first ODD episode for this beneficiary) in which the beneficiary received behavioral health medications – must be under maximum threshold of 20%.

3. Percentage of repeat episodes (i.e., all episodes other than a PAP’s first ODD episode for this beneficiary) for which the beneficiary received behavioral health medications – must be equal to 0%.

4. Percentage of episodes resulting in beneficiary remission (no repeat ODD episode for this beneficiary within 180 days after the end of the episode) – must meet minimum threshold of 40%. If a PAP has <5 episodes used for the calculation in a performance period, the metric becomes a quality measure “to track” – not “to pass”.

B. Quality measures “to track”:

1. Percentage of episodes with >9 visits over >30 days

2. Percentage of episodes certified as non-guideline concordant care

3. Average number of visits per episode

4. Average number of behavioral therapy visits per episode

215.600 Thresholds for Incentive Payments

A. The acceptable threshold is $2,671.

B. The commendable threshold is $1,642.

C. The gain sharing limit is $552.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

215.700 Minimum Case Volume

The minimum case volume is 5 cases per 12-month period.

216.000 COLONOSCOPY EPISODES

216.100 Episode Definition/Scope of Services

A. Episode subtypes:

There are no subtypes for this episode type.

B. Episode trigger:

Outpatient colonoscopy procedure (including balloon, biopsy, polypectomy, etc.) and primary or secondary diagnosis indicating conditions that require a colonoscopy (e.g., colorectal bleeding, hemorrhoids, anal fistula, neoplasm of unspecified nature). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. Episode duration:

Episodes begin 30 days prior to procedure after and including the initial consult with the performing provider, and extend within 30 days after the procedure.
D. **Episode services:**

The episode will include all of the following services rendered within the episode’s duration:

1. Within 30-day pre-procedure window: related services beginning on the day of the first consult with the performing provider, including inpatient and outpatient facility services, professional services, related medications, and excluding ER visits on the day of the first visit.

2. Within procedure window: colonoscopies with and without additional procedures, including inpatient and outpatient facility services, professional services, and related medications, beginning day of procedure.

3. Within 30-day post-procedure window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, inpatient post-procedure admission (excluding those defined by Bundled Payments for Care Improvement (BPCI)).

**216.200 Principal Accountable Provider**

The Principal Accountable Provider (PAP) for an episode is the primary provider performing the colonoscopy.

**216.300 Exclusions**

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries with select comorbid conditions within 365 days prior to procedure or during episode (e.g., inflammatory bowel disease, select cancers, select transplants, etc.). For a complete list of comorbidities, please see the code sheet associated with the episode.

B. Beneficiaries under the age of 18 or over the age of 64 at the time of the procedure.

C. Beneficiaries who are pregnant during the episode.

D. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible).

E. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode.

F. Beneficiaries who die in the hospital during the episode.

G. Beneficiaries with patient status “left against medical advice” during the episode.

**216.400 Adjustments**

The cost of this episode is based on a) risk factors (e.g., renal failure, diabetes) and b) episode types. Episode types include 1) colonoscopies with additional procedures, 2) colonoscopies without additional procedures.

**216.500 Quality Measures**

A. **Quality measures “to pass”:**

1. Cecal intubation rate reported by provider on an aggregated quarterly basis – must meet minimum threshold of 75%.

2. In at least 80% of valid episodes, the withdrawal time must be greater than 6 minutes.

B. **Quality measures “to track”:**
1. Perforation rate
2. Post polypectomy/biopsy bleed rate

All of the above quality measures “to pass” require providers to submit data through the provider portal.

216.600 Thresholds for Incentive Payments

A. The acceptable threshold is $886.

B. The commendable threshold is $796.

C. The gain sharing limit is $717.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

216.700 Minimum Case Volume

The minimum case volume is 5 total cases per 12-month period.

217.000 TONSILLECTOMY EPISODES

217.100 Episode Definition/Scope of Services

A. Episode subtypes:
There are no subtypes for this episode type.

B. Episode trigger:
Episode is triggered by an outpatient tonsillectomy, adenoidectomy, or adeno-tonsillectomy procedure, and a primary or secondary diagnosis (Dx1 or Dx2) indicating conditions that require tonsillectomy/adenoidectomy (e.g., chronic tonsillitis, chronic adenoiditis, chronic pharyngitis, hypertrophy of tonsils and adenoids, obstructive sleep apnea, insomnia, peritonsillar abscess). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. Episode duration:
Episodes begin 90 days prior to procedure after and including the initial consult with performing provider, and end 30 days after the procedure.

D. Episode services:
The following services are included in the episode:

1. Within 90 days prior to procedure: initial consult with performing provider, and any related services including sleep studies, head and neck X-rays, and laryngoscopy

2. The tonsillectomy/adenoidectomy procedure

3. Within 30 days after procedure: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, and post-procedure admissions (excluding those defined by Bundled Payments for Care Improvement (BPCI))
For each episode, the Principal Accountable Provider (PAP) is the primary provider performing the tonsillectomy/adenoidectomy.

**217.300 Exclusions**

Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries who are under the age of 3 or above the age of 21 at the time of the procedure

B. Beneficiaries with select comorbid conditions (e.g., Down syndrome, cancer, severe asthma, cerebral palsy, muscular dystrophy, myopathies). For a complete list of comorbidities, please see the code sheet associated with the episode.

C. Beneficiaries with an Uvulopalatopharyngoplasty (UPPP) on date of procedure

D. Beneficiaries with a BMI>50

E. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

F. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

G. Beneficiaries who die in the hospital during the episode

H. Beneficiaries with a patient status of “left against medical advice” during the episode

**217.400 Adjustments**

For the purpose of determining a PAP’s performance, the total reimbursement attributable to the PAP is adjusted for tonsillectomy episodes within certain risk factors (e.g., COPD, asthma), and depending on type. There are two episode types: 1) adenoidectomy and 2) tonsillectomy/adeno-tonsillectomy.

**217.500 Quality Measures**

A. **Quality measures “to pass”**:  
   1. Percent of episode with administration of intra-operative steroids – must meet minimum threshold of 85%

B. **Quality measures “to track”**:  
   1. Post-operative primary bleed rate (i.e., post-procedure admissions or unplanned return to OR due to bleeding within 24 hours of surgery)
   2. Post-operative secondary bleed rate
   3. Rate of antibiotic prescription post-surgery

All of the above quality measures “to pass” require providers to submit data through the provider portal.

**217.600 Thresholds for Incentive Payments**

A. The acceptable threshold is $1,003.

B. The commendable threshold is $974.

C. The gain sharing limit is $824.

D. The gain sharing percentage is 50%.
E. The risk sharing percentage is 50%.

217.700 Minimum Case Volume
The minimum case volume is 5 total cases per 12-month period.

218.000 CHOLECYSTECTOMY EPISODES

218.100 Episode Definition/Scope of Services

A. Episode subtypes:
There are no subtypes for this episode type.

B. Episode trigger:
Episode is triggered by open or laparoscopic cholecystectomy procedure, and a primary or secondary diagnosis (Dx1 or Dx2) indicating conditions related to cholecystectomy (e.g., cholelithiasis, cholecystitis). For a complete list of diagnoses, please see the code sheet associated with the episode.

C. Episode duration:
Episodes begin with the cholecystectomy procedure and end 90 days post-procedure.

D. Episode services:
The following services are included in the episode:

1. During procedure: Cholecystectomy surgery and related services (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)

2. Within 90 days post-procedure: related services (i.e., inpatient and outpatient facility services, professional services, related medications, treatment for complications)

3. Within 30-day post-procedure window: related services including inpatient and outpatient facility services, professional services, related medications, treatment for post-procedure complications, inpatient post-procedure admission (excluding those defined by Bundled Payments for Care Improvement (BPCI))

218.200 Principal Accountable Provider
For each episode, the Principal Accountable Provider (PAP) is the primary surgeon performing the cholecystectomy.

218.300 Exclusions
Episodes meeting one or more of the following criteria will be excluded:

A. Beneficiaries who are less than or equal to the age of 1 or greater than or equal to the age of 65 at the time of the procedure

B. Beneficiaries with select comorbid conditions or past procedures within 365 days or 90 days after cholecystectomy (e.g., HIV, cancer, sickle cell anemia, transplants). For a complete list of comorbidities, please see the code sheet associated with the episode.

C. Beneficiaries with a pregnancy 30 days prior to 90 days after a cholecystectomy procedure

D. Beneficiaries with ICU care within 30 days prior to the cholecystectomy procedure

E. Beneficiaries with acute pancreatitis, cirrhosis, or cholangitis concurrent with procedure
Episodes of Care

Section II

F. Beneficiaries with open cholecystectomy procedure (includes laparoscopic converted to open and surgeries initiated open)

G. Beneficiaries who die in the hospital during the episode

H. Beneficiaries with a patient status of “left against medical advice” during the episode

I. Beneficiaries with dual enrollment in Medicare/Medicaid (i.e., dual-eligible)

J. Beneficiaries who do not have continuous Medicaid enrollment for the duration of the episode

218.400 Adjustments

For the purposes of determining a PAP’s performance, the total reimbursement attributable to the PAP is adjusted for: cholecystectomy episodes in which patients have comorbidities, including indirectly related health conditions (e.g., acute cholecystitis, common bile duct stones), and episodes in which patients have an ED admittance prior to procedure.

218.500 Quality Measures

A. Quality measures “to pass”:
   1. Percent of episodes with CT scan prior to cholecystectomy – must be below threshold of 44%

B. Quality measures “to track”:
   1. Rate of major complications that occur in episode, either during procedure or in post-procedure window: common bile duct injury, abdominal blood vessel injury, bowel injury
   2. Number of laparoscopic cholecystectomies converted to open surgeries
   3. Number of cholecystectomies initiated via open surgery

218.600 Thresholds for Incentive Payments

A. The acceptable threshold is $1,919.

B. The commendable threshold is $1,581.

C. The gain sharing limit is $1,337.

D. The gain sharing percentage is 50%.

E. The risk sharing percentage is 50%.

218.700 Minimum Case Volume

The minimum case volume is 5 total cases per 12-month period.