ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) EPISODES

Episode Definition/Scope of Services

A. Episode subtypes:
   1. Level I: Episode of care for an ADHD beneficiary with no behavioral health comorbid conditions and for whom no qualifying Severity Certification has been completed.
   2. Level II: Episode of care for an ADHD beneficiary with no behavioral health comorbid conditions who has had an inadequate response to medication management. Providers must complete a Severity Certification through the provider portal to qualify beneficiaries for a Level II designation.

B. Episode trigger:
   Level I subtype episodes are triggered by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD. Level II subtype episodes are triggered by a completed Severity Certification followed by either two medical claims with a primary diagnosis of ADHD or a medical claim with a primary diagnosis of ADHD as well as a pharmacy claim for medication used to treat ADHD.

C. Episode duration:
   The standard episode duration is a 12-month period beginning at the time of the first trigger claim. A Level I episode will conclude at the initiation of a new Level II episode if a Severity Certification is completed during the 12-month period.

D. Episode services:
   All claims with a primary diagnosis of ADHD as well as all medications indicated for ADHD or used in the treatment of ADHD.

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

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.

If the provider responsible for the largest number of claims is a physician or an RSPMI provider organization, that provider 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.

If the provider responsible for the largest number of claims is a licensed clinical psychologist operating outside of an RSPMI provider organization, that provider is a co-PAP with the physician or RSPMI provider providing the next largest number of claims within the episode. 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 co-PAP.

Where there are co-PAPs for an episode, the positive or negative supplemental payments are divided equally between the co-PAPs.

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

212.400 Adjustments

Total reimbursement attributable to the PAP for episodes with a duration of less than 12 months will be scaled linearly to determine a reimbursement per 12-months for the purpose of calculating the PAP's performance.

212.500 Quality Measures

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

B. Quality measures “to track”:
   1. In order to track and evaluate selected quality measures, providers are asked to complete a “Quality Assessment” certification (for beneficiaries new to the provider) or a “Continuing Care” certification (for beneficiaries previously receiving services from the provider)
   2. Percentage of episodes classified as Level II
   3. Average number of physician visits/episode
   4. Percentage of episodes with medication
   5. Percentage of episodes certified as non-guideline concordant
   6. Percentage of episodes certified as non-guideline concordant with no rationale

212.600 Thresholds for Incentive Payments

A. ADHD Level I
   1. The acceptable threshold is $2,223.
   2. The commendable threshold is $1,547.
   3. The gain sharing limit is $700.
   4. The gain sharing percentage is 50%.
   5. The risk sharing percentage is 50%.

B. ADHD Level II
   1. The acceptable threshold is $7,112.
   2. The commendable threshold is $5,403.
   3. The gain sharing limit is $2,223.
   4. The gain sharing percentage is 50%.
   5. The risk sharing percentage is 50%.
212.700 Minimum Case Volume

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

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 comorbid behavioral health condition

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

215.400 Adjustments

An episode with fewer than 10 therapy visits over 30+ days will not be applied to reduce a PAP’s average episode cost but may count toward risk sharing. PAPs who in an entire performance
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period have no episodes with 10 or more therapy visits over 30+ days will not be eligible for gain sharing.

215.500 Quality Measures

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

5. Percentage of episodes with >9 therapy sessions over a period of 30+ days and of which >7 are family therapy sessions (CPT 90846 OR CPT 90847)

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 $984.

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.