<table>
<thead>
<tr>
<th>Triggers</th>
<th>ODD episodes are triggered by three medical claims with a primary diagnosis of ODD.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PAP assignment</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Exclusions</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Episode time window</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Claims included</strong></td>
<td>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.”</td>
</tr>
<tr>
<td><strong>Quality measures</strong></td>
<td><strong>Quality measures “to pass”:</strong> 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 &lt;5 episodes used for the calculation in a performance period, the metric becomes a quality measure “to track” – not “to pass”.</td>
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</tbody>
</table>
### 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 period have no episodes with 10 or more visits over 30+ days will not be eligible for gain sharing.

This is implemented through the following steps:
- Episode minimum care indicates whether “10 or more visits over >30 days” was achieved for each episode
- PAP average cost is calculated without episodes that did not meet minimum care if they would lower average cost
- PAP gain sharing is only paid out if at least 1 episode met minimum care levels

### Trigger codes

- Diagnosis or medication that would trigger the episode
- **ICD-9 codes (on Professional claim):** 313.81
- **CPT codes for assessment:** 90801, 96101, 96118, T1023

### Exclusion codes

The following ICD-9 diagnoses exclude an episode. The same diagnosis must appear at least twice within the year to qualify for exclusion.


These codes represent the set of business and clinical exclusions described previously

### Included claim codes

- Any claim with a primary diagnosis of ODD– defined by the following ICD-9 codes – is included.
  - **ICD-9-CM code:** 313.81

Further, all pharmacy claims for medications with the following HIC3 classification are tracked for quality metrics but not included in episode cost calculation.


List of CPT codes for behavioral therapy claims within the episode
- **Behavioral therapy visits:** 90846, 90847, 90849, 90853, 90887, 97110, 97150, 97530, 97532, 97535, H0004, H0046, H2011, H2015, H2017, H2012