**HEALing Communities Quality Measure Databook: Measure Descriptions**

**OQPS HEAL Measures found in CDMOWN**

|  |  |  |  |
| --- | --- | --- | --- |
| Measure Number | Measure Description | Numerator | Denominator |
| 2.4 | Number of Individuals with Opioid Use Disorder (prevalence) | Of individuals in the denominator, count of unique individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time during the measurement period | Count of unique Medicaid enrollees |
| 2.5.2 | Number of Individuals Receiving Methadone | Count of unique individuals who had at least one procedure code for methadone or had a claim prior to the measurement period which supplied at least one day in the measurement period. | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.5.3 | Number of Individuals Receiving Naltrexone | Of individuals in the denominator, count those who had a claim for naltrexone at any point during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.5.4 | Number of Individuals with Opioid Use Disorder (OUD) Receiving Medication for Opioid Use Disorder (MOUD) - [Hypothesis H3] | Count of individuals in the denominator who had at least one claim with a National Drug Code (NDC) for any of the following OUD medications during the measurement period: buprenorphine, Naltrexone (oral), Injectable Naltrexone, Buprenorphine/ Naltrexone, or a procedure code for any OUD medications. | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.5.5 | Number of Individuals with Opioid Use Disorder (OUD) Receiving buprenorphine products that are FDA approved for treatment of OUD | Of individuals in the denominator, count those who had a claim for buprenorphine products that are FDA approved for treatment of OUD at any point during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.1 | Number of individuals with OUD receiving behavioral health treatment (inpatient, ASAM levels 3,4) | Count of individuals in the denominator who had at least one claim with Inpatient Detox/Rehabilitation Treatment Center (corresponding to ASAM Levels 3,4) service during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.2 | Number of individuals with OUD receiving behavioral health treatment (IOP, ASAM level 2) | Count of individuals in the denominator who had at least one claim with Intensive outpatient (IOP) behavioral health services or Partial Hospitalization (corresponding to ASAM level 2) service during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.3 | Number of individuals with OUD receiving behavioral health treatment (outpatient, ASAM level 1) | Count of individuals in the denominator who had at least one claim with Outpatient behavioral health services (corresponding to ASAM level 1) service during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.4 | Number of individuals with OUD receiving behavioral health treatment (any of ASAM levels 1-4) | Count of individuals in the denominator who had at least one claim with Any Behavioral Health treatment (any of ASAM levels 1-4) during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.5 | Number of individuals with OUD receiving behavioral health treatment (case mgmt) | Count of individuals in the denominator who had at least one claim with Case management or targeted case management (T2023-with co-occurring mental health, T2023) + other case management codes during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.6 | Number of individuals with OUD receiving behavioral health treatment (peer support) | Count of individuals in the denominator who had at least one claim with Peer support during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.7 | Number of individuals with OUD receiving behavioral health treatment (any of case mgmt, peer support) | Count of individuals in the denominator who had at least one claim with Peer support or Care management during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.6.8 | Number of individuals with OUD receiving behavioral health treatment (screening) | Count of individuals in the denominator who had at least one claim with Screening assessment during the measurement period | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.7.2 | Number of Individuals Receiving Methadone Retained beyond 6 months | Count of individuals in the denominator, treated with Methadone, with a gap of no more than 7 days, within the measurement period. | Count of unique individuals who had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time during the measurement period and a claim for Naltrexone, followed by a period of 6 months continuous enrollment during the measurement period. |
| 2.7.4 | Number of Individuals with MOUD Retained in Treatment beyond 6 Months | Count of individuals in the denominator, treated with Medication assisted treatment for opioid use disorder (MOUD), with a gap of no more than 7 days, within the measurement period. | Count of unique individuals who had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time during the measurement period and a claim for Naltrexone, followed by a period of 6 months continuous enrollment during the measurement period. |
| 2.7.5 | Person-Months in MOUD | Count of individuals in the denominator, treated with Medication assisted treatment for opioid use disorder (MOUD), with a gap of no more than 7 days, within the measurement period. | Count of person-months for individuals, who had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.7.6 | Number of Individuals receiving buprenorphine products that are FDA approved for treatment of OUD that are retained beyond 6 months | Count of individuals in the denominator, treated with buprenorphine products that are FDA approved for treatment of OUD, with a gap of no more than 7 days, within the measurement period. | Count of unique individuals who had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time during the measurement period and a claim for MOUD, followed by a period of 6 months continuous enrollment during the measurement period. |
| 2.9.1 | Number of Individuals Linked to MOUD following Opioid Overdose | Count of individuals who had an event in the denominator, that had at least one claim for naltrexone, methadone maintenance treatment, or buprenorphine within 31 days of ED visit date (inclusive, of the ED visit date). | Count of unique individuals who had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time during the measurement period and a claim for MOUD, followed by a period of 6 months continuous enrollment during the measurement period. |
| 2.9.2 | Number of Opioid overdoses in which the individual was connected with MOUD within 31 days | Count of opioid overdoses in which the individual had at least one claim for MOUD claim in the 31 days following the opioid overdose event inclusive of the date of the event | Count of unique individuals who had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position at any time during the measurement period and a claim for MOUD, followed by a period of 6 months continuous enrollment during the measurement period. |
| 2.12.1 | Number of Individuals Linked to MOUD following Opioid-related ED Visit within 31 days | Count of individuals with an opioid-related ED events in the denominator, that had at least one claim for naltrexone, methadone maintenance treatment, or buprenorphine within 31 days of ED visit date, inclusive of the event date. | Count of individuals with an opioid-related ED events during the measurement period |
| 2.12.2 | Number of opioid-related ED visits with MOUD follow-up within 30 days | Count of opioid-related ED events in the denominator, that had at least one claim for naltrexone, methadone maintenance treatment, or buprenorphine within 31 days of ED visit date, inclusive of the event date. | Count of individuals with an opioid-related ED events during the measurement period |
| 2.15.1 | Number of Individuals with OUD who are Screened for Hepatitis C | Count of individuals in the denominator who had at least one claim for Screening for Hepatitis C (HCV). | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.15.2 | Number of Individuals with OUD who are Diagnosed with Hepatitis C | Count of individuals in the denominator who had at least one claim for diagnosis of Hepatitis C (HCV). | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |
| 2.15.3 | Number of Individuals with OUD who are Treated for Hepatitis C | Count of individuals in the denominator who had at least one claim for treatment for Hepatitis C (HCV). | Count of all individuals that had an OUD diagnosis in any setting (inpatient, outpatient, or professional claims), in any position during the 12 month (365) days preceding or during the measurement period. |

**HEAL Economic Measures**

Denominator Value: Non-Dual Individuals who had Medicaid enrollment at any point during the measurement period.

Red Comments: Clarification/modification based on discussions with HEAL team and NYS Medicaid to better align with NYS Medicaid Definitions

|  |  |  |
| --- | --- | --- |
| Measure Number | Measure Description | Numerator |
| M 4.1.1 | Number of Behavioral Health Emergency Department Visits | Count the number of unique ED visits where there is a primary or first-listed (if no primary) BH diagnosis (ICD-10-CM ranges F01–F69, F90–F99) or an any listed poisoning code (ICD-10-CM range T36–T50: Poisoning by drugs, medicaments and biological substances listed).  Primary or first-listed (if primary dx not available) BH diagnosis: F01–F69; F90–F99  or  Any listed poisoning by drugs, medicaments and biological substances listed: T36–T50  Codes to identify ED records:  Either  procedure code: 99281, 99282, 99283, 99284, 99285, 99288  or  revenue code: 450, 451, 452, 456, 459, 981  or  place of service code: 23  To better align with NY-specific practices, the approved categorization for emergency department claims – based on claim class, bill type, place of service, revenue code, and rate code – is used, rather than the above. See data governance definition (“ER Executive Summary - OHIP Data Governance\_10032022.docx”) for details. This categorization considers only institutional claims for ED services.  Strategy to identify unique ED visits:  Use claim ID number and transaction control number to identify line items that are part of the same ED visit.  Transaction control number, TCN, is used to identify unique ED visits. |
| M 4.1.2 | Number of Non-Behavioral Health Emergency Department Visits | Across all individuals in the denominator, count the number of unique ED visits where there is NOT a primary or first-listed (if primary dx not available) behavioral health diagnosis (ICD-10-CM ranges F01–F69, F90–F99) and NOT an any listed poisoning code (ICD-10-CM range T36–T50: Poisoning by drugs, medicaments and biological substances listed).  Not  Primary or First-listed (if primary dx not available) BH diagnosis: F01–F69; F90–F99  And not  Any listed poisoning by drugs, medicaments and biological substances listed: T36–T50  Either  procedure code: 99281, 99282, 99283, 99284, 99285, 99288  or  revenue code: 450, 451, 452, 456, 459, 981  or  place of service code: 23  To better align with NYS Medicaid-specific practices, the approved categorization for emergency department claims – based on claim class, bill type, place of service, revenue code, and rate code – is used, rather than the above. See data governance definition (“ER Executive Summary - OHIP Data Governance\_10032022.docx”) for details. This categorization considers only institutional claims for ED services.  Strategy to identify unique ED visits:  Use claim ID number and transaction control number to identify line items that are part of the same ED visit.  Transaction control number, TCN, is used to identify unique ED visits. |
| M 4.2.1 | Number of Non-Detox Behavioral Health Hospital/Inpatient Nights | Count the number of inpatient nights, across all inpatient stays, where there is either a primary behavioral health diagnosis (ICD-10-CM ranges F01–F69, F90–F99) or there is a secondary poisoning code (ICD-10-CM range T36–T50: Poisoning by drugs, medicaments and biological substances listed) and there is not a detox code.  Primary BH diagnosis: F01–F69; F90–F99 (primary diagnosis code)  or  Any listed poisoning by drugs, medicaments and biological substances listed: T36–T50 (secondary diagnosis code)  And not  Revenue code: 116, 126, 136, 146, 156  And not  Procedure code: HZ2ZZZZ (may be surgical procedure code), H0009  Code to identify inpatient records  If available, use claim type = “I”  If not available, use revenue code 100–219 (exclude 116, 126, 136, 146, 156)  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details. Claims for graduate medical education, identified by rate codes 3130-3137, are removed.  Identifying unique inpatient stays (where there may be multiple service records)  Within individuals’ service utilization, if there is ≤ 1 day gap between inpatient stays and the provider is the same, they are part of the same unique inpatient stay  Calculating number of nights  Single record: Number of nights is equal to the discharge date minus the admission date  Multiple records: Number of nights is equal to the last record’s discharge date minus the first record’s admission date  Diagnosis, revenue, and procedure codes to use when there are multiple service records  Where there are multiple service records, use diagnosis, revenue, and procedure codes from the first record  Attribution of inpatient stays to relevant month and year  All nights for an inpatient stay should be attributed to the month and year of the admission date  This rule applies even when inpatient stays extend over multiple months or years  For inpatient stays with multiple records, all nights for the inpatient stay are attributed to the month/year of the first record’s admission date. |
| M 4.2.2 | Number of Detox Hospital/Inpatient Nights | Across all individuals in the denominator, count the number of inpatient nights, across all inpatient stays, where there is a detox code of the following:  Revenue code: 116, 126, 136, 146, 156  or  Procedure code: h0009, HZ2ZZZZ (may be surgical procedure code and a Ohio specific code)  Code to identify Inpatient records  If available, use claim type = “I”  If not available, use revenue code 100–219  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx”) for details. Claims for graduate medical education, identified by rate codes 3130-3137, are removed.  How to identify unique inpatient stays (where there may be multiple service records)  Within individuals’ service utilization, if there is ≤1 day gap between inpatient stays and the provider is the same, they are part of the same unique inpatient stay  Calculating number of nights  Number of nights is equal to the discharge date minus the admission date  Where there are multiple service records, Number of nights is equal to the last record’s discharge date minus the first record’s admission date  Diagnosis, revenue, and procedure codes to use when there are multiple service records  Where there are multiple service records, use diagnosis, revenue, and procedure codes from the first record  Attribution of inpatient stays to relevant month and year  All nights for an inpatient stay should be attributed to the month and year of the admission date  This rule applies even when inpatient stays extend over multiple months or years  For inpatient stays with multiple records, all nights for the inpatient stay are attributed to the month/year of the first record’s admission date. |
| M 4.2.2 | Number of Non-Behavioral Health Hospital/Inpatient Nights | Across all individuals in the denominator, count the number of inpatient nights, across all inpatient stays, where there not a primary behavioral health diagnosis (ICD-10-CM ranges F01–F69, F90–F99) nor is there is a secondary poisoning code (ICD-10-CM range T36–T50: Poisoning by drugs, medicaments and biological substances listed), nor is there a detox code.  Not  Primary BH diagnosis: F01–F69; F90–F99 (primary diagnosis code)  And not  Any listed poisoning by drugs, medicaments and biological substances listed: T36–T50 (secondary diagnosis code)  And not  Revenue code: 116, 126, 136, 146, 156  And not  Procedure code: HZ2ZZZZ (may be surgical procedure code), H0009  Code to identify Inpatient records  If available, use claim type = “I”  If not available, use revenue 100–219, excluding 116, 126, 136, 146, 156  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details. Claims for graduate medical education, identified by rate codes 3130-3137, are removed.  How to identify unique inpatient stays (where there may be multiple service records)  Within individuals’ service utilization, if there is ≤ 1 day gap between inpatient stays and the provider is the same, they are part of the same unique inpatient stay  Calculating number of nights  Number of nights is equal to the discharge date minus the admission date  Where there are multiple service records, Number of nights is equal to the last record’s discharge date minus the first record’s admission date  Diagnosis, revenue, and procedure codes to use when there are multiple service records  Where there are multiple service records, use diagnosis, revenue, and procedure codes from the first record  Attribution of inpatient stays to relevant month and year  All nights for an inpatient stay should be attributed to the month and year of the admission date  This rule applies even when inpatient stays extend over multiple months or years  For inpatient stays with multiple records, all nights for the inpatient stay are attributed to the month/year of the first record’s admission date. |
| M 4.3.1 | Number of Behavioral Health Non-Detox Residential Nights | Across all individuals in the denominator, count the number of behavioral health residential nights.  Contains either:  Place of service code: 55, 56  or  Procedure codes: H0017, H0018, H0019, H2034, H2036  or  Revenue codes: 1001, 1002  And not  Procedure codes: H0010, H0011  Claims and encounters without a submitted discharge date or service end date are excluded from analysis.  Attribution of residential stays to relevant month and year  All nights for a residential stay should be attributed to the month and year of the admission date  This rule applies even when residential stays extend over multiple months or years  Apply the rule of a gap of 2 days or more to be a discontinuation or a break in the residential stay. Thus the gap would not be counted in the sum of residential nights.  For residential stays with multiple records, all nights for the residential stay are attributed to the month/year of the first record’s admission date. |
| M 4.3.2 | Number of Behavioral Health Detox Residential Nights | Across all individuals in the denominator, count the number of behavioral health residential detox nights.  Procedure codes: H0010, H0011  Attribution of residential stays to relevant month and year  All nights for a residential stay should be attributed to the month and year of the admission date  This rule applies even when residential stays extend over multiple months or years  Apply the rule of a gap of 2 days or more to be a discontinuation or a break in the residential stay. Thus the gap would not be counted in the sum of residential nights.  For residential stays with multiple records, all nights for the residential stay are attributed to the month/year of the first record’s admission date. |
| M 4.4.1 | Number of Intesive Outpatient Vistis | Across all individuals in the denominator, count the number of intensive outpatient visits.  Contain either:  Revenue codes: 905, 906, 907, 912, 913  or  Procedure codes: H0015, H0035, S9480, S0201  Strategy to identify unique IOP visits:  Use claim ID number and transaction control number to identify line items that are part of the same IOP visit.  Outpatient visits are calculated as unique combinations of members, billing provider, and service date. |
| M 4.5.1 | Number of Behvioral Health Outpatient Visits | Across all individuals in the denominator, count the number of outpatient visits with a behavioral health diagnosis code. BH diagnosis codes are F01–F69; F90–F99.  Outpatient visits are calculated as unique combinations of members, billing provider, and service date.  Contains  Primary BH diagnosis: F01–F69; F90–F99 (primary diagnosis code)  And  Place of service: 02, 03, 04, 05, 06, 07 08, 11, 12, 14, 15, 16, 17, 18, 19, 20, 22, 24, 49, 50, 53, 57, 58, 62, 71, 72  And not  Procedure code: 99281, 99282, 99283, 99284, 99285, 99288, H2034, H2036, H0010, H0011, H0015, H0017, H0018, H0019, H0035, S9480, S0201  And not  revenue code: 100–219; 450, 451, 452, 456, 459, 981, 905, 906, 907, 912, 913, 1001, 1002  And not  claim type = “I”  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details. |
| M 4.5.2 | Number of Non-Behavioral Health Outpatient Visits | Across all individuals in the denominator, count the number of outpatient visits that do NOT have a behavioral health diagnosis code. BH diagnosis codes are F01 – F69; F90 – F99.  Outpatient visits are calculated as unique combinations of members, billing provider, and service date.  Contains  Place of Service: 02, 03, 04, 05, 06, 07 08, 11, 12, 14, 15, 16, 17, 18, 19, 20, 22, 24, 49, 50, 53, 57, 58, 62, 71, 72  And not  Primary BH diagnosis: F01–F69; F90–F99 (primary diagnosis code)  And not  Procedure code: 99281, 99282, 99283, 99284, 99285, 99288, H2034, H2036, , H0010, H0011, H0015, H0017, H0018, H0019, H0035, S9480, S0201  And not  revenue code: 100 – 219; 0450, 0451, 0452, 0456, 0459, 0981, 905, 906, 907, 912, 913, 1001, 1002  And not  Use claim type = “I”  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details |
| M 4.6.1 | Number of Non-Pain Buprenorphine Days Supplied | Across all individuals in the denominator, count the number of days supplied that are Non-Pain buprenorphine. This will require three steps. First, count the days supplied from prescription fills using the NDC list (see HCS central NDC list for qualifying NDC codes). Second, count the days supplied of office administered oral buprenorphine using procedure codes. Third, sum the total days supplied across the two data sources.  OHIP uses the following HCPCS procedure codes for office-administered oral buprenorphine: J0571, J0572, J0573, J0574, J0575, G2068, G2079.  Procedure codes (may vary by state: use procedure codes and qualifying criteria that reflect state policy). For outpatient procedure codes, do not include claims where claim type = “I”.  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details.  Attribution of prescription fill or office administered buprenorphine to relevant month and year  All days supplied for a prescription fill or office administration should be attributed to the month and year of the prescription fill date or claim date, respectively.  This rule applies even when the days supplied extend over multiple months or years  Days supplied should be counted as the number of days covered. For example, if a prescription is for 30 units but 2 per day, days supplied is 15.  For pharmacy claims, days supplied is sourced from the SUPPLY\_DAYS field encounters and is attributed to the month/year of service (SRV\_DT).  For office-administered oral buprenorphine, days supply can be converted from procedure code, using the crosswalk “CDM Days Supply.xlsx” provided by NYS Office of Quality and Patient Safety (OQPS) on 10/05.   * **J0571, J0572, J0573, J0574, J0575 are used for daily oral buprenorphine administration, and each service is counted as a 1 day supplied.** * **G2068 and G2079 are used for weekly/take-home buprenorphine administration, and each service is counted as 7 days supplied.** |
| M 4.6.2 | Number of Non-Pain Buprenorphine Injections | Across all individuals in the denominator, count the number of claims that are Non-Pain Buprenorphine injections, plus the number of prescription fills that are Non-Pain Buprenorphine injections.  The numerator is calculated at the claim line level (distinct claim\_trans\_id), instead of the claim level (TCN), to accurately capture number of injections rather than number of claims, based on clarification from the HEAL team.  Procedure codes (may vary by state: use procedure codes and qualifying criteria that reflect state policy); NDC list (see HCS central NDC list for qualifying NDC codes). For outpatient procedure codes, do not include claims where claim type = “I”.  Document containing NDCs for buprenorphine injections (“KY Medispan Export 20220810.xlsx”) provided by HEAL team to NYS Medicaid via email on 8/18.  NYS Medicaid uses the following HCPCS procedure codes for buprenorphine injections: Q9991, Q9992.  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx”) for details. |
| M 4.6.3 | Number of Opioid Related Oral Naltrexone Days Supplied | Across all individuals in the denominator, count the number of prescription days supplied that are opioid related oral naltrexone fills. NDC list (see HCS central NDC list for qualifying NDC codes)  Attribution of prescription fill to relevant month and year  All days supplied for a prescription fill should be attributed to the month and year of the prescription fill date  This rule applies even when the days supplied extend over multiple months or years  Days supplied should be counted as the number of days covered. For example, if a prescription is for 30 units but 2 per day, days supplied is 15.  Days supplied is sourced from the SUPPLY\_DAYS field on pharmacy claims and encounters and is attributed to the month/year of service (SRV\_DT). |
| M 4.6.4 | Number of Opioid Related Naltrexone Injections | Across all individuals in the denominator, count the number of claims that are a Naltrexone injection, plus the number of prescription fills that are a Naltrexone injection.  The numerator is calculated at the claim line level (distinct claim\_trans\_id), instead of the claim level (TCN), to accurately capture number of injections rather than number of claims.  Procedure codes (may vary by state: use procedure codes and qualifying criteria that reflect state policy) NDC list (see HCS central NDC list for qualifying NDC codes). For outpatient procedure codes, do not include claims where claim type = “I”.  NYS Medicaid uses the following HCPCS procedure code for naltrexone injections: J2315  To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details. |
| M 4.6.5 | Number of Methadone Days Supplied | Across all individuals in the denominator, count the number of days methadone was supplied. Each state has its own algorithm for calculating days’ supply.  Attribution of methadone administration to relevant month and year  All days supplied for methadone administration should be attributed to the month and year of the methadone administration date  This rule applies even when the days supplied extend over multiple months or years  Days supplied should be counted as the number of days covered. For example, if 30 units are given but instructions are to take 2 per day, days supplied is 15.  Use procedure codes to identify office based methadone (states should use MOUD procedure codes and criteria that best reflect state methadone policy and coding). Because these are office based claims, do not include claims where claim type = “I”.  Procedure codes for MOUD vary by state. Most states use procedure code H0020 for methadone administration. Each state will need to implement its own algorithm based on the details below to accurately sum up the number of days methadone was supplied, across all individuals in the denominator.  **Ohio:** Uses H0020 for methadone administration. Without a modifier, H0020 is for a single in person administration (i.e., 1 day supplied). For take-home doses supplied, Ohio uses the following modifiers: ‘HF’=1 day; ‘TV’=1 week; ‘UB’=2 weeks; ‘TS’=3 weeks; ‘HG’=4 weeks.  **New York:** Uses H0020 for methadone administration. **Prior to March 16, 2020**, providers had the option of billing daily or weekly. For daily visits, the first visit of the week required a ‘KP’ modifier to get a higher reimbursement; the rest of the week did not have a modifier. NY stated that it can determine whether the code is being used as a daily claim or as a weekly claim and count days supplied accordingly. **Starting on March 16, 2020**, new take-home dispensing codes were introduced. G2067 and G2078 are both used to specify a weekly (i.e., 7 days) dispensed amount. H0020 can still be billed in this new period.  **Kentucky:** Uses H0020 as a weekly bundle code. There is no difference in billing practices for take-home amounts. Thus, an instance of an H0020 code is equivalent to 7 days supplied.  **Massachusetts:** Uses H0020 as a daily claim. There is no difference in billing practices for take-home amounts. Thus, an instance of an H0020 code is equivalent to 1 day supplied.  Days supplied is not reported on professional/institutional claims for methadone administration for NY; however, the procedure codes are tied to a daily/weekly supply and can be used to calculate days supplied.   * + **H0020 is used for daily methadone administration, and each service is counted as 1 day supplied.**   + **G2067 and G2078 are used for weekly/take-home methadone administration, and each service is counted as 7 days supplied.**   To better align with NYS Medicaid specific practices, the approved categorization for inpatient claims – based on claim class, bill type code, and revenue code – is used, rather than claim type “I” or the above revenue codes. See data governance definition (“[Inpatient Definition Executive Summary - OHIP Data Governance\_08312021.docx](https://nysemail.sharepoint.com/sites/Healthexternal/OHIPDG/Lists/Completed%20Categorization%20Definitions/Attachments/1/Inpatient%20Definition%20Executive%20Summary%20-%20OHIP%20Data%20Governance_08312021.docx?web=1)”) for details. |
| M 4.7.1 | Number of Opioid Pain Medication Days Supplied | Across all individuals in the denominator, count the number of prescription days supplied that are opioid pain medication fills. NDC list (see HCS central NDC list for qualifying NDC codes)  Document containing NDCs for opioid pain medication (“KY Medispan Export 20220810.xlsx”) provided by HEAL team to NYS Medicaid via email on 8/18.  Attribution of prescription fill to relevant month and year  All days supplied for a prescription fill should be attributed to the month and year of the prescription fill date  This rule applies even when the days supplied extend over multiple months or years  Days supplied should be counted as the number of days covered. For example, if a prescription is for 30 units but 2 per day, days supplied is 15.  Days supplied is sourced from the SUPPLY\_DAYS field on pharmacy claims and encounters and is attributed to the month/year of service (SRV\_DT). |
| M 4.7.2 | Number of Non-Opioid Pain Medications Days Supplied | Across all individuals in the denominator, count the number of prescription days supplied that are non-opioid pain medication fills. NDC list (see HCS central NDC list for qualifying NDC codes)  Attribution of prescription fill to relevant month and year  All days supplied for a prescription fill should be attributed to the month and year of the prescription fill date  This rule applies even when the days supplied extend over multiple months or years  Days supplied should be counted as the number of days covered. For example, if a prescription is for 30 units but 2 per day, days supplied is 15.  Days supplied is sourced from the SUPPLY\_DAYS field on pharmacy claims and encounters and is attributed to the month/year of service (SRV\_DT). |