CHEAT SHEET FOR USING CLAIMS DATA TO MEASURE THE PERCENT OF CHILDREN SCREENED TO IDENTIFY DEVELOPMENTAL CONCERNS

Overview of Using CLAIMS DATA as a Data Source for Measurement:

Claims data come from the claims that providers submit in order to obtain payment for the services they provide. Each claim includes information and codes that, among other things, identify the service(s) provided, when it was provided and who received it. The codes that identify the services provided can be based on Current Procedural Terminology (CPT) and/or state-specific Healthcare Common Procedure Coding System (HCPCS) codes for screening. Claims data is a commonly used data source for measurement as it is a standardized data source summarizing specific services that are reimbursed. Valid and feasible methods exist for using claims data to create measures related to rates of children receiving specific services and/or visits (e.g. well-child visits). Claims data can also serve as a useful template for a measure focused on the percent of children screened using a standardized tool.

Measure of the Percent of Children Screened Using CLAIMS DATA:

Numerator: Number of children for whom a claim (*such as CPT codes 96110, 96111, 99420*) of standardized screening was submitted during the specified time period and who had an eligible visit for screening

Denominator: Number of eligible children who had a specified visit and who should have been screened during the intervention time period.

X 100

Key Clarifying Questions to Ask in Using the CLAIMS DATA to Measure % of Children Screened

The following questions need to be carefully answered in order to include detailed, specific information in the claims data abstraction tools that will be used to collect data to measure the percent of children screened.

Clarifying Questions Related to the Numerator:

- **What billing code (CPT or state-specific HCPCS) will be used to identify whether standardized screening occurred?**
  - Commonly used claims include **CPT codes 96110*** or **96111*.** These codes have been approved by CMS.
  - The American Academy of Pediatrics Statement on Identifying Infants and Young Children with Developmental Disorders in the Medical Home (July, 2006) provides a detailed description of claims that can be used for standardized screening.
  - DBpeds.org also has a section focused on claims that can be used: http://www.dbpeds.org/articles/detail.cfm?id=123

- **Is that code routinely used?**
  - Providers may not know that they can (or should) use code that indicates standardized screening. If they know that they can use the code they still may not routinely include the code on the claim. It is important to examine the claims data to ensure that

providers are using the codes. If they are not routinely used, then the claims data will not be valid for measuring whether screening is occurring.
  - For the required measurement of screening in the pilot practices, claims data should ONLY be used in the states with established use of and provider understanding about how to bill for standardized screening within and outside a well-child visit.

- **Are there limits to when and at what visit that code can be used?**
  - Submitted claims are processed to determine whether they qualify for payment. This process may for example, deny payment if more than one screen is provided on the same day to the same beneficiary or if a screen is provided outside of a well-child visit. It is important to examine these payment requirements to make sure that needed data will be included in the claims data.
  - Claims data may include both paid and unpaid claims.

- **Periodicity Issues: When and how often should the screening occur?**
  - The specifications for examining the claims need to take into account the recommended periodicity of the screening.
  - An example of a periodicity schedule is the *AAP Statement on Identifying Infants and Young Children with Developmental Disorders in the Medical Home* (July, 2006) recommends children be screened with a standardized tool at the 9-month, 18-month and 30-month (and if the provider does not do a 30-month visit, then the 24-month visit)
  - If age-specific algorithms are established based on identified visits, it is important to consider lags between when a child is supposed to receive care and when they may actually come in. For example, it is important to identify children who may have come in for their "9-month visit" when they were actually 10 months old.

- **What is the length of time between when a claim is submitted and when it appears in the claims database?**
  - In some states, the claims data lag can be as long as six-months. This will need to be accounted for in planning for the baseline and periodic measurements that are conducted for the practice sites.
    - Given the length of the Screening Academy, if the claims data lag is significant, alternate data sources should be examined as periodic measurement and reporting of the results is invaluable to guide improvements to the implementation.

- **What is the source for the claims data?**
  - Claims data is limited to the source of the data. Therefore, if Medicaid claims data is used only screens paid for by Medicaid will be included in the numerator.

Clarifying Questions Related to the Denominator:

- **Who should have been screened?**
  For the claims data, this group of children will be selected based on a set of criteria that will identify children with specific characteristics. These criteria can be anchored to the following:
  - **Visit**: Should only children who have had specific kinds of visits be included? (i.e., if there is no claim indicating that the child had a specific type of visit should the child be excluded from the denominator?
    - The CAHMI recommends limiting the denominator to only children who had one or more well-child visits during the period of time being assessed.
  - **Age of Child**: Should claims for children of certain ages be examined? Should age-specific denominators be established to examine standardized screening conducted at specific well-child visits?
    - For example, should age-specific samples from the claims data be drawn for the age-periods at which a child should be screened based on the AAP statement (*e.g. Group 1: Children for whom a claim was submitted for 9-month well child visit, Group 2: children for whom a claim was submitted for the 18-month well child visit, and Group 3: children for whom a claim was submitted for receiving the 30-month (or 24-month) well-child visit.*)
    - If so, it is important to consider lags between when a child is supposed to receive care and when they may actually come in. For example, it is important to identify children who may have come in for their "9-month visit" when they were actually 10 months old.
  - **Length of Enrollment:** Should only children who have been enrolled in the health system for a specific time be included in the denominator?
    - This information is not based on the child's utilization of care, but is based on administrative information related to the child's health insurance.
    - A common example of an enrollment criterion is the requirement for the child to have at least six-months of continuous enrollment, allowing for a one-month gap in enrollment.
  - **Language**: In what language(s) is the standardized developmental screening tool being administered? Is it possible to identify the language of the child in the claims data and to possibly remove those who were ineligible for the standardized screening because the tool was not available in their language?
  - **Need criteria**: Should children already identified with developmental concerns be screened?
    - If not, are there feasible methods to identify these children in the claims data and remove them from the sample of eligible charts to review?

Other General Issues Related to Using Claims data to Evaluate Efforts Over Time

- **Unit of analysis:** It is important to consider who is being assessed (e.g. the "unit") and whether the claims data can validly be specified to those health care providers. This will ensure that valid methods are used to measure and evaluate the efforts underway.
  - For example, most offices are comprised of more than one provider. If all of the providers are participating in the screening project, then office-level sampling can be

conducted in such a way that takes into account the number of providers in each office.
    - However, if only specific providers are participating then standardized and valid methods are needed to identify specific providers for whom the claim can be associated.
    - Past CAHMI studies of Medicaid claims data have shown that while the claims data can often be associated with the provider who serves as the child's primary care provider, the claims billed may have been received from another provider in the office. Conversely, if in trying to assess care for specific providers, limiting the data to just children enrolled with that specific provider may not accurately narrow the denominator to children actually served by that provider given the observed variations between the person who provides care and who is listed as the primary care provider.

Tips for Enhancing the Feasibility of Claims Data Reviews

- **Develop standardized methods for how the claims data will be analyzed.**
  - These instructions are central to obtaining valid and useable information.
  - Existing instructions from currently used measures based on claims data can serve as a template (e.g. Measures to create rates for children who received well-child care).

- **If possible, identify existing measurement activities and resources using claims data and "add on" this component.**
  - Claims data is commonly used for quality measurement. Identify persons with the established skills, resources and related priorities for quality measurement using claims data who can assist in this measurement activity. Examples of related existing quality measurement activities include the following:
    - Assessment of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) rates.
    - State performance measures evaluating the state quality strategy and activities.
    - Required performance measures of managed care organizations and other Medicaid providers.
    - Required measures evaluating performance improvement projects.

- **Periodically report the findings to the providers of care being assessed AND to those assisting in the survey administration.**
  - Report the information in a way that is salient and relevant to the user.
  - Reporting information about the findings can guide improvements to the implementation AND increase understanding about the value and relevancy of the data which can enhance support for the survey administration process.