COLORADO
Department of Health Care Policy & Financing

30 Day Follow-Up Care Following Inpatient Discharge

Measure Description

Rate of discharges from an inpatient hospital stay in which patients receive follow-up care with a physician within 30 days.

Evaluation Period

Rolling 12 month; 90 days claims run out

Numerator

E&M Claim within 30 days of inpatient discharge

Condition Description	# Event	Detailed Criteria	Criteria Connector	Timeframe
Client had a subsequent Evaluation and Management Claim within 30 days of inpatient discharge	1	CPT Procedure Code in (99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245)		Within 30 days from Date of Discharge of the original inclusion Claim Note: Do not include BHO encounters.

Denominator

Members will be counted in the denominator if they meet the following criteria:

- Clients who are discharged from an inpatient hospital stay, who have not had a subsequent readmission.
- Are enrolled in the ACC as the Enrollment Date (defined above)

Denominator Units: Distinct count of inpatient hospital stays meeting the above criteria. A client can have multiple IP stays and can be counted multiple times in the reporting period.

Denominator Eligibility/Enrollment Inclusion Criteria:

Condition Description	# Event	Detailed Criteria	Timeframe
Clients discharged from an inpatient hospital stay (Inpatient, Skilled Nursing, Medicare Part A Crossover).	1	Claim Type: 'I' or 'A' for Inpatient) Note: since QME cannot use claim type, these will be mapped to revenue code 0100 at the header	Discharge 30 days on or prior to the first day of the reporting period and 30 days prior to the last day of the reporting period (i.e. for the reporting period ending 12/31/2016, the denominator date range would be 12/02/15 to 12/01/16.)
		Provider type <> 20 (Nursing Facility), 36 (HCBS)	
		Discharge status <> 02, 03, 04, 05, 09, 20, 21, 30, 31, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70	
Enrolled in the ACC	1	Eligibility effective date <= enrollment date Eligibility end date >= enrollment date	Last month of the 12-month rolling evaluation period

Denominator Exclusions

Condition Description	# Event	Detailed Criteria	Timeframe
Discharges that result in readmission within 30 days	1	Claim Type: 'I' or 'A' for Inpatient) Note: since QME cannot use claim type, these will be mapped to revenue code 0100 at the header	Discharge 30 days on or prior to the first day of the reporting period and 30 days prior to the last day of the reporting period (i.e. for the reporting period ending 12/31/2016, the denominator date range would be 12/02/15 to 12/01/16.)
		Provider type <> 20 (Nursing Facility), 36 (HCBS)	
		Discharge status <> 02, 03, 04, 05, 09, 20, 21, 30, 31, 40, 41, 42, 43, 50, 51, 61, 62, 63, 64, 65, 66, 70	
		Readmission 1st date of service is 30 days or less after previous discharge	

Members will be excluded from the denominator if they meet the following criteria:

- Members who are dually eligible or enrolled in the ACC. Medicare-Medicaid Program (MMP).
- Members who were enrolled in any physical health managed care plan for more than 3-month anytime during the evaluation period.
- Members with less than 3 months of Medicaid eligibility.

Notes

- Only PAID claims will be considered as part of the numerator/denominator/exclusion criteria.