Use of Services

Specific Guidelines for Use of Services Measures

Guidelines

1. **Measures similar to Effectiveness of Care measures.** Four nontabular Use of Services measures have the same structure as the measures in the Effectiveness of Care domain.

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits

The MCO should follow the *Specific Guidelines for Effectiveness of Care Measures* when calculating these measures.

2. **Continuous enrollment criteria.** Continuous enrollment requirements apply to the following measures.

- Frequency of Ongoing Prenatal Care
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits

The MCO should follow the guidelines on continuous enrollment provided in the *General Guidelines.*

Specific Instructions for Use of Services Tables

3. **Members who switch product lines.** Unless otherwise specified, assign MCO members to the product in which they are enrolled on the date of service for the relevant service. If the service is an inpatient admission, use the member's discharge date to assign the product line. Assign Medicaid members to the Medicaid-eligibility category (e.g., Medicaid/Medicare, the disabled) based on the date of service or date of discharge (inpatient) for the relevant service.

4. **Member month vs. member year reporting.** Report Use of Services tables on the basis of *member years* for commercial and Medicare members and *member months* for Medicaid members. This acknowledges that Medicaid beneficiary enrollment in managed care tends to be less stable than enrollment of commercial or Medicare members.

5. **Services provided during the measurement year.** Report information on services that occurred during the measurement year in the Use of Services tables.

6. **Which services count?** Report all services for which the MCO actually paid or expects to pay (i.e., claims incurred but not yet paid). *Do not include* services and days denied for any reason. In cases where a member is enrolled retroactively, count all services that the MCO has paid or expects to pay for.

7. **Medicaid eligibility reporting categories.** For the MCO's HEDIS report on the Medicaid product line, report certain use of services data separately for each of the following eligibility categories:

- *Medicaid/Medicare.* Medicaid beneficiaries who are Medicaid/Medicare dual-eligibles should be included in both Medicaid and Medicare HEDIS reports if the MCO has a Medicare Advantage contract. If the members have Medicare Fee for Service or unknown Medicare coverage as their primary insurer, then the members may be excluded from the Medicaid reports.
- *The disabled.* Medicaid beneficiaries who are not dually eligible and whose Medicaid eligibility is determined wholly or in part on the basis of a disability.
- *Low income.* Medicaid beneficiaries who are neither Medicare recipients nor disabled and who are entitled to a state's full Medicaid-covered services (e.g., "other low-income" beneficiaries).
- *Total Medicaid.* Medicaid beneficiaries from all three reporting categories described above, along with individuals to whom the state offers a restricted benefit package (such as pregnant women who are entitled only to pregnancy-related services or other groups entitled only to limited services such as emergency services). Medicaid beneficiaries with a restricted benefit package are not reported separately because of anticipated small numbers.

8. **Stratification by product line/eligibility category.** Members covered by different product lines tend to vary considerably by sociodemographic characteristics and enrollment and utilization patterns. For this reason, report Use of Services measures separately for each product line (Medicaid, commercial, Medicare).

For Medicaid members only, report the Use of Services measures by eligibility category. Throughout the Use of Services domain, tables that apply to each measure are designated as follows (where **XXX** is the abbreviation for a specific measure).

- *Table **XXX**-1a* Total Medicaid
- *Table **XXX**-1b* Medicaid/Medicare Dual-Eligibles
- *Table **XXX**-1c* Medicaid—Disabled
- *Table **XXX**-1d* Medicaid—Other Low Income
- *Table **XXX**-2* Commercially Enrolled—by Product or Combined HMO/POS
- *Table **XXX**-2e* Commercially Enrolled—Employer/Purchaser-Specific
- *Table **XXX**-3* Medicare

Medicaid members. Refer to the *Enrollment by Product Line* measure in the Health Plan Descriptive Information domain for a detailed definition of the Medicaid eligibility categories.

Note that Medicaid enrollees who have a restricted benefit package are not reported separately, but are included in Table XXX-1a (Total Medicaid). The sum of Table XXX-1b (Medicaid/Medicare Dual-Eligibles), Table XXX-1c (Disabled) and Table XXX-1d (Other Low Income), therefore, does not equal Table XXX-1a (Total Medicaid). Information on the categorization of Medicaid enrollees is to be provided to the MCO by the state. If a state does not provide this data, the MCO may report "Total Medicaid" only.

Report Medicare/Medicaid members in Table XXX-1a and Table XXX-1b, regardless of the type of Medicare coverage. Report Medicaid/Medicare dual-eligibles in Table XXX-3 (Medicare) if the MCO holds a Medicare Advantage contract.

Commercial members. Report "direct pay" and "group" enrollees as commercial enrollees. Table 2 reports the MCO's commercial enrollees. Table XXX-2e (Employer/Purchaser-Specific) reports on enrollees covered by a particular employer or purchaser.

Use of Services measures will have up to seven tables. Complete only the tables relevant to the MCO (i.e., tables reflecting the product lines that the MCO serves). Because utilization patterns vary with product line characteristics, there is no "total" Use of Services table summarizing information on all enrolled MCO members.

9. **Member months and member year calculation.** For some Use of Services measures, a table for reporting member months by age category (and gender category, if required) is provided. The MCO should complete the tables for all members with the relevant benefit during the measurement year using the following guidelines and formulas:

Member months are a member's "contribution" to the total yearly membership.

Step 1 Determine member months using a specified day of each month (e.g., the 15th or the last day of the month), to be determined according to the MCO's administrative processes. The day selected must be consistent from member to member, month to month and from year to year. For example, if the MCO tallies membership on the 15th of the month and Ms. X is enrolled in the MCO on January 15, Ms. X contributes one member month in January.

Retroactive enrollment. The MCO may include in these member months any months in which members were enrolled retrospectively and for which the MCO received a retroactive capitation payment.

Step 2 Use the member's age on the specified day of each month to determine to which age group the member months will be contributed. For example, if an MCO tallies membership on the 15th of each month and Ms. X turns 25 on April 3 and is enrolled for the entire year, then she contributes three member months (January, February and March) to the 20–24 age category and nine member months to the 25–29 age category.

Member years serve as a proxy for annual membership and are calculated as:

X member months/12 months = Y member years.

10. **Matching enrollment with utilization.** The MCO should run enrollment reports used for member month calculations to determine utilization rates (such as days/1,000 members per year) within 30 days of the claims reports and for the same time period. These reports should include retroactive additions and terminations.

11. **Reporting outpatient services.** To report outpatient procedures and services, the MCO should count the total number of specified services it paid for, or expects to pay for, during the measurement year. Use the formulas and guidelines below to complete the tables:

Age of members Report age as of the date of service.

Counting multiple services In general, if a patient receives the same service or procedure at two different times (e.g., CABG procedures six months apart), count them as two procedures. Count services, not the frequency of procedure codes billed (e.g., if a surgeon and a hospital submit separate bills pertaining to the same surgical episode with the same date of service, only one should be included in use of services data). The MCO must develop its own systems to avoid double counting.

Visits per 1,000 member months	(Total visits/member months) x 1,000.
Visits per 1,000 member years	(Total visits/member months) x 1,000 x 12.

12. **Reporting inpatient services—discharges.** The MCO should identify inpatient utilization and report by discharge date rather than admission date, because reporting by discharge date promotes increased consistency between HEDIS reports and other national reporting clinical databases and ensures more complete and timely data submissions. The MCO should include all discharges that occurred during the measurement year and should use the guidelines and formulas outlined below.

Coding	The use of DRGs is preferred to report discharges. If DRGs are unavailable, the MCO should use the other specified methods (e.g., ICD-9-CM codes).
Age of members	Unless otherwise specified, report member age as of the date of service. If the service is an inpatient stay, use age as of the date of discharge.
Counting multiple services	In general, if a patient receives the same service or procedure at two different times (e.g., CABG procedures six months apart), count them as two procedures. Count services, not the frequency of procedure codes billed (e.g., if a surgeon and a hospital submit separate bills pertaining to the same surgical episode with the same date of service, only one should be included in use of services data). The MCO must develop its own systems to avoid double counting.
Counting transfers	Treat transfers *between* institutions as separate admissions. Base transfer reports *within* an institution upon the type and level of services provided. Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/chemical dependency and non-mental health/chemical dependency services. Count only one admission when the transfer takes place within the same service category but to a different level of care; for example, from intensive care to a lesser level of care or from a lesser level of care to intensive care.
Mental health and chemical dependency transfers	Count as a separate admission a transfer within the same institution but to a different level of care (e.g., a transfer between inpatient, residential care or intermediate care). Each level should appropriately include discharges and length of stay (inpatient days should be counted under inpatient and intermediate days should be counted under intermediate).
Discharges	Total discharges associated with particular diagnosis codes. If the MCO is unable to report by discharge date, it should report data by admission date and indicate the reason.
Discharges/1,000 member months (Medicaid)	(Total discharges/member months) $\times$ 1,000.
Discharges/1,000 members per year (Medicare and commercial)	(Total discharges/member months) $\times$ 1,000 $\times$ 12.

Discharges/1,000 female member months, stratified (Medicaid)	Member months within the particular age and sex category specified in each row of the table. For example, [(total discharges for female members 20–34) ÷ (member months of female members 20–34)] × 1,000.
Discharges/1,000 female members per year, stratified (Medicare and commercial)	Members within the particular age and sex category specified in each row of the table. For example, [(total discharges for female members 20–34 years) ÷ (member months of female members 20–34)] × 1,000 × 12.

13. **Reporting inpatient services—length of stay and days.** The MCO should use the formulas below to report length of stay (LOS), average length of stay (ALOS) and total days:

LOS	All approved days from admission to discharge. The last day of the stay is not counted unless the admission and discharge date are the same. LOS = discharge date – admit date – denied days.

Note: *When an inpatient Revenue code (i.e., UB-92 or equivalent code) is associated with a stay, the LOS must equal at least one day. If the discharge date and the admission date are the same, then the discharge date minus admission date equals one day, not zero.*

ALOS	Total days/total discharges.
Total days incurred	The sum of the length of stay for all discharges during a measurement year. The total does not include the last day of the stay (unless the last day of stay is also the admit day) or denied days. Total days include days that occur before January 1 of the measurement year for discharge dates occurring during the measurement year. Total days incurred does not include days occurring during the measurement year that are associated with discharge dates in the year after the measurement year. Total days incurred = sum of LOS for each discharge during the measurement year.
Total days incurred/ 1,000 members/year	(Total days incurred/member months) × 1,000 × 12.

Frequency of Ongoing Prenatal Care (FPC)

SUMMARY OF CHANGES TO HEDIS 2007

- This measure uses coding tables from the Prenatal and Postpartum Care measure. Refer to the Prenatal and Postpartum Care measure for changes to the coding tables.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow the* Specific Guidelines for Effectiveness of Care Measures *when calculating this measure.*

Description

The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year and uses the same denominator and deliveries as the *Prenatal and Postpartum Care* measure.

For these deliveries, the MCO:

- Identifies the actual number of prenatal care visits rendered while the members were enrolled in the MCO.
- Identifies the number of expected visits.
- Calculates the ratio of received-to-expected visits.
- Reports an unduplicated count of deliveries who had <21 percent, 21–40 percent, 41–60 percent, 61–80 percent or ≥81 percent of the number of expected visits, adjusted for the month the member enrolled and the MCO and gestational age. The MCO reports five rates.

Eligible Population

Product line	Medicaid.
Age	None specified.
Continuous enrollment	43 days prior to delivery through 56 days after delivery.
Allowable gap	No allowable gap during the continuous enrollment period.
Anchor date	Date of delivery.
Benefit	Medical.
Event/diagnosis	*Delivered a* live *birth on or between November 6 of the year prior to the measurement year and November 5 of the measurement year.* Women who delivered in a birthing center should be included in this measure. Refer to Table PPC-A and Table PPC-B. *Multiple births.* Women who had two separate deliveries (different dates of service) between November 6 of the year prior to the measurement year and November 5 of the measurement year should count twice. Women who have multiple live births during one pregnancy should be counted once in the measure. The MCO must exclude members for whom a prenatal visit is not indicated. These exclusions are indicated by a dash (–) in Table FPC-A.

Administrative Specification

Denominator The eligible population.

Numerator Women who had an unduplicated count of <21 percent, 21–40 percent, 41–60 percent, 61–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. Use the steps listed below to calculate each woman's ratio of observed-to-expected prenatal care visits.

For each delivery included in the denominator:

Step 1 Identify the delivery date using hospital discharge data.

Step 2 Identify the date on which the member enrolled in the MCO and determine the stage of pregnancy at time of enrollment. If the member has gaps in enrollment during pregnancy, use the last enrollment segment calculation from the Prenatal and Postpartum Care measure to determine enrollment in the MCO.

The MCO should use the following approach (or an equivalent method) to calculate the stage of pregnancy at time of enrollment. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

- Convert gestational age into days.
- Subtract gestational age (in days) from the date of delivery (step 1).
- Subtract the date obtained above from the date on which the member enrolled in the MCO to determine the stage of pregnancy at time of enrollment.
- Divide the numbers of days the member was pregnant at enrollment (step 3) by 30. Round the resulting number up or down according to the .5 rule to the next whole number.

  For example, delivery date is August 8, 2006; gestational age is 33 weeks; date of enrollment is May 6, 2006. Given these variables, the process is:
  - Gestational age in days is 231 days (33 weeks × 7 days/week).
  - Date of delivery – gestational age (in days) is December 22, 2005 (August 8, 2006 – 231 days).
  - Date on which the member enrolled in the MCO – date obtained in step 2 is 135 days (May 6, 2006 – December 22, 2005).
  - Month in which prenatal care began is 4.5 months (135 days/30 days) and then round up to 5 months using the 0.5 rule.

This member's stage of pregnancy at time of enrollment is 5 months.

Step 3 Use Table FPC-A to find the number of recommended prenatal visits by gestational age and stage of pregnancy at time of enrollment per the American College of Obstetricians and Gynecologists (ACOG). The chart subtracts the number of missed visits prior to the date the member enrolled from the number of recommended visits for a given gestational age.

ACOG recommends that women with an uncomplicated pregnancy receive visits every 4 weeks for the first 28 weeks of pregnancy, every 2–3 weeks until 36 weeks of gestation, and weekly thereafter. For example, ACOG recommends 14 visits for a 40-week gestation. If the member enrolled during her fourth month (3 missed visits prior to enrollment in the MCO), the expected number of visits is 14 – 3 = 11.

For deliveries with a gestational age <28 weeks or >42 weeks, the MCO should calculate the expected number of prenatal care visits using the date on which the member enrolled and ACOG's recommended schedule of visits. For example, if gestational age is 26 weeks and the member enrolled during her second month of pregnancy, the expected number of prenatal care visits is 5 (6 expected visits [1 visit every 4 weeks or 6 visits in 24 weeks], less 1 visit missed in the first month).

If gestational age is 43 weeks and the member enrolled during her third month of pregnancy, the expected number of prenatal care visits is 15 (14 expected visits for a 40-week gestation plus 1 visit each additional week [17 total expected prenatal care visits], less 2 visits missed in the first and second months).

Step 4 Identify the number of prenatal care visits the member received during the course of her pregnancy and while enrolled in the MCO using ambulatory encounter data. To identify prenatal visits that occurred during the first trimester, the MCO should use Table PPC-C. The MCO may use any of the four rules presented in the table to search for evidence of prenatal care; a woman's record only needs to satisfy one rule.

To identify prenatal visits that occurred during the second and third trimester, the MCO should use Table PPC-D. Visits that occur on the date of delivery and meet the prenatal visit criteria count toward the measure. The MCO should document its methodology for identifying prenatal care, whether or not these decision rules were followed.

Step 5 Calculate the ratio of observed visits (step 5) over expected visits (step 4).

Step 6 Report each woman in the appropriate category.

- <21 percent
- 21–40 percent
- 41–60 percent
- 61–80 percent
- ≥81 percent of expected visits

Note: *The MCO should refer to Appendix 3 for the definition of* primary care practitioner *and* OB/GYN practitioner. *Ultrasound and lab visits should not be included in this measure unless they are a part of the office visit with a physician.*

Hybrid Specification

Denominator A systematic sample of members drawn from the eligible population. If the MCO collects this measure and the *Prenatal and Postpartum Care* measure, it must use the same systematic sample for both. The MCO may reduce the sample size using the current year's lowest product-line-specific administrative rate for the rate of women who received ≥81 percent of expected prenatal care visits and the two rates from *Prenatal and Postpartum Care.* It may also use the prior year's lowest audited product-line-specific rates for the rate of women who received ≥81 percent of expected prenatal care visits and the two rates from Prenatal and Postpartum Care.

Note: *For information on reducing sample size, refer to the* Guidelines for Calculations and Sampling.

Numerator Women who had an unduplicated count of the number of expected visits that was <21 percent, 21–40 percent, 41–60 percent, 61–80 percent or ≥81 percent of the number of expected visits, adjusted for the month of pregnancy at time of enrollment and gestational age. The visits may be identified through either administrative data or medical record review.

The numerator is calculated retroactively from date of delivery or EDD.

Note: *The MCO should refer to Appendix 3 for the definition of* primary care practitioner *and* OB/GYN practitioner.

Administrative Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Use the medical record documentation requirements in the Prenatal and Postpartum Care measure, in the Access/Availability of Care domain to identify prenatal visits.

Identify gestational age at birth from the hospital record (e.g., admission write-ups, histories and physicals, discharge summaries or labor and delivery records) or birth certificate. **Gestational age** is the number of completed weeks that have elapsed between the first day of the last normal menstrual period and the date of delivery. If gestational age is not available, assume a gestational age of 280 days (40 weeks).

Methods recommended to determine gestational age are:

- Physician ascertainment using ultrasound or Dubowitz assessment
- Last menstrual period (LMP) calculation (date of LMP – date of delivery) ÷ 7. If gestational age is recorded or calculated in fractions of a week, round down to the lower whole number.

Note

- *This measure is based on deliveries. Members who have multiple deliveries from a single pregnancy should be counted once. Include each pregnancy for members who have multiple deliveries from different pregnancies.*
- *When counting prenatal visits, include visits to nurse practitioners, midwives and registered nurses, provided that evidence of cosignature by a physician is present, if required by state law.*

- *If the MCO collected both Prenatal and Postpartum Care and Frequency of Ongoing Prenatal Care measures and plans to report using the Hybrid method, both measures must be collected using the same sample. An MCO that employs the Hybrid method may not use a combination of administrative data and medical record review to identify prenatal care visits for an individual in the denominator. For example, for one member, the MCO may not count two prenatal care visits identified through administrative data and another three visits identified through medical record review (for a total of five prenatal care visits) for one member, even if each visit shows a different date of service.*

Table FPC-A: Expected Number of Prenatal Care Visits for a Given Gestational Age and Month Member Enrolled in the MCO*

	Gestational Age in Weeks														
Month of Pregnancy Member Enrolled in the MCO	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
9th month	–	–	–	–	–	–	–	–	–	–	–	1	1	2	3
8th month	–	–	–	–	–	–	1	1	1	2	3	4	5	6	7
7th month	–	–	1	1	1	1	2	2	3	4	5	6	7	8	9
6th month	1	1	1	1	2	2	3	3	4	5	6	7	8	9	10
5th month	1	1	2	2	3	3	4	4	5	6	7	8	9	10	11
4th month	3	3	4	4	5	5	6	6	7	8	9	10	11	12	13
3rd month	4	4	5	5	6	6	7	7	8	9	10	11	12	13	14
2nd month	5	5	6	6	7	7	8	8	9	10	11	12	13	14	15
1st month	6	6	7	7	8	8	9	9	10	11	12	13	14	15	16

* Source: *Guidelines for Perinatal Care, Fifth Edition*. American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table FPC-1: Data Elements for Frequency of Ongoing Prenatal Care

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 5 rates*
Current year's administrative rate (before exclusions)		*Each of the 5 rates*
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		*Each of the 5 rates*
Administrative rate on FSS		*Each of the 5 rates*
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 5 rates*	*Each of the 5 rates*
Numerator events by medical records		*Each of the 5 rates*
Reported rate	*Each of the 5 rates*	*Each of the 5 rates*
Lower 95% confidence interval	*Each of the 5 rates*	*Each of the 5 rates*
Upper 95% confidence interval	*Each of the 5 rates*	*Each of the 5 rates*

Well-Child Visits in the First 15 Months of Life (W15)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The percentage of enrolled members who turned 15 months old during the measurement year and who had 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a primary care practitioner during their first 15 months of life.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow* Specific Guidelines for Effectiveness of Care Measures *when calculating this measure.*

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Age	15 months old during the measurement year.
Continuous enrollment	31 days–15 months of age. Calculate 31 days of age by adding 31 days to the child's date of birth. Calculate the 15-month birthday as the child's first birthday plus 90 days. For example, a child born on January 9, 2005, and included in the rate of six or more well-child visits must have had six well-child visits by April 9, 2006.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	Day the child turns 15 months old.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a primary care practitioner during their first 15 months of life. To count toward the measure, the well-child visit must occur with a primary care practitioner, but it does not have to be the practitioner assigned to the child. A child who had a claim/encounter from a primary care practitioner with a code listed in Table W15-A is considered to have received a well-child visit.

Table W15-A: Codes to Identify Well-Child Visits

CPT	ICD-9-CM Diagnosis
99381, 99382, 99391, 99392, 99432	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Note: *An MCO with internal codes or other transaction data not cited above for Medicaid members that denote an EPSDT well-child visit may use these codes as long as they document methods used to track EPSDT well-child visits.*

Hybrid Specification

Denominator

A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate for six or more visits, or the prior year's audited, product line-specific rate for six or more visits.

Note: *For information on reducing sample size, refer to the* Guidelines for Calculations and Sampling.

Numerators

Seven separate numerators are calculated, corresponding to the number of members who received 0, 1, 2, 3, 4, 5, 6 or more well-child visits with a primary care practitioner during their first 15 months of life.

To count toward this measure, the well-child visit must occur with a primary care practitioner.

Administrative

Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record

Documentation from the medical record must include a note indicating a visit with a primary care practitioner, the date the well-child visit occurred and evidence of all of the following.

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

Note

- *Preventive services may be rendered on the occasion of visits other than well-child visits. These services count if the specified codes are present, regardless of the primary intent of the visit. Do not include services rendered during an inpatient or emergency department visit.*
- *The MCO may count services that occur over multiple visits toward this measure as long as all of the services occur within the time frame established in the measure.*
- *An MCO using the Hybrid method may use a combination of administrative data and medical record review to identify well-child visits for an individual in the denominator as long as the dates of service are at least two weeks apart. For example, the MCO may count two well-child visits identified through administrative data and another visit identified through medical record review (a total of three well-child visits) for one member, if each visit shows a different date of service and the dates are at least two weeks apart.*
- *The MCO should refer to* Appendix 3 *for the definition of* primary care practitioner. *This includes the use of nonphysician practitioners such as nurse practitioners or physician assistants.*

- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. The MCO should reference the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and* Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents *(published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more detailed information on what constitutes a well-child visit.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements:

Table W15-1/2: Data Elements for Well-Child Visits in the First 15 Months of Life

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 7 rates*
Current year's administrative rate (before exclusions)		*Each of the 7 rates*
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		*Each of the 7 rates*
Administrative rate on FSS		*Each of the 7 rates*
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	*Each of the 7 rates*	*Each of the 7 rates*
Numerator events by medical records		*Each of the 7 rates*
Reported rate	*Each of the 7 rates*	*Each of the 7 rates*
Lower 95% confidence interval	*Each of the 7 rates*	*Each of the 7 rates*
Upper 95% confidence interval	*Each of the 7 rates*	*Each of the 7 rates*

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

The percentage of members who were three, four, five or six years of age who received one or more well-child visits with a primary care practitioner during the measurement year.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow* Specific Guidelines for Effectiveness of Care Measures *when calculating this measure.*

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	3–6 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1 gap in enrollment of up to 45 days during the continuous enrollment period. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	At least one well-child visit with a primary care practitioner during the measurement year. To count toward the measure, the well-child visit must occur with a primary care practitioner, but it does not have to be the practitioner assigned to the child. A child who had a claim/encounter from a primary care practitioner with one of the codes listed in Table W34-A is considered to have received a well-child visit.

Table W34-A: Codes to Identify Well-Child Visits

CPT	ICD-9-CM Diagnosis
99382, 99383, 99392, 99393	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Note: *An MCO with internal codes, or other transaction data not cited above for Medicaid members that denote an EPSDT well-child visit, may use these codes as long as it documents the method used to track EPSDT well-child visits.*

Hybrid Specification

Denominator A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.

Note: *For information on reducing sample size, refer to the* Guidelines for Calculations and Sampling.

Numerator At least one well-child visit with a primary care practitioner during the measurement year. The primary care practitioner, however, does not have to be the practitioner assigned to the child.

Administrative Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.

Medical record Documentation must include a note indicating a visit to a primary care practitioner, the date on which the well-child visit occurred and evidence of all of the following.

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

Note

- *Preventive services may be rendered on the occasion of visits other than well-child visits. These services count if the specified codes are present, regardless of the primary intent of the visit. Do not include services rendered during an inpatient or emergency department visit.*
- *Visits to school-based clinics with practitioner types that the MCO would consider as primary care practitioners may be counted if documentation of a well-child exam is available in the medical record or administrative system before December 31 of the measurement year (i.e., entries made retroactive to the measurement year are not counted). The primary care practitioner does not have to be assigned to the member.*
- *The MCO may count services that occur over multiple visits toward this measure as long as all services occur within the time frame established in the measure.*
- *The MCO should refer to Appendix 3 for the definition of* primary care practitioner*. This includes the use of nonphysician practitioners such as nurse practitioners and physician assistants.*
- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. The MCO should reference the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and* Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents *(published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more detailed information on what constitutes a well-child visit.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table W34-1/2: Data Elements for Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Adolescent Well-Care Visits (AWC)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Note: *This measure has the same structure as measures in the Effectiveness of Care domain. The MCO should follow* Specific Guidelines for Effectiveness of Care Measures *when calculating this measure.*

Description

The percentage of enrolled members who were 12–21 years of age and who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year.

Eligible Population

Product lines	Commercial, Medicaid (report each product line separately).
Ages	12–21 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	Members who have had no more than 1 gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid member for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage (i.e., a member whose coverage lapses for 2 months [60 days] is not considered continuously enrolled).
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Administrative Specification

Denominator	The eligible population.
Numerators	At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. The primary care practitioner does not have to be assigned to the member. Adolescents who had a claim or encounter with a primary care practitioner or OB/GYN practitioner with one of the codes listed in Table AWC-A are considered to have received a comprehensive well-care visit.

Table AWC-A: Codes to Identify Adolescent Well-Care Visits

CPT	ICD-9-CM Diagnosis
99383-99385, 99393-99395	V20.2, V70.0, V70.3, V70.5, V70.6, V70.8, V70.9

Note: *An MCO with internal codes, or other transaction data not cited above for Medicaid members that denote an EPSDT well-child visit, may use these codes as long as it documents the method used to track EPSDT well-child visits.*

Hybrid Specification

Denominator A systematic sample drawn from the MCO's eligible population. The MCO may reduce its sample size using the current year's administrative rate or the prior year's audited, product line-specific rate.

Note: *For information on reducing sample size, refer to the* Guidelines for Calculations and Sampling.

Numerators At least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year, as documented through either administrative data or medical record review.

The primary care practitioner does not have to be assigned to the member.

Administrative Refer to the *Administrative Specification* listed above to identify positive numerator hits from the administrative data.

Medical record Documentation in the medical record must include, a note indicating a visit to a primary care practitioner or OB/GYN practitioner, the date on which the well-care visit occurred and, evidence of all of the following.

- A health and developmental history (physical and mental)
- A physical exam
- Health education/anticipatory guidance

Note

- *Preventive services may be rendered on the occasion of visits other than well-child visits. These services count if the specified codes are present, regardless of the primary intent of the visit. Do not include services rendered during an inpatient or emergency department visit.*
- *Visits to school-based clinics with practitioner types that the MCO would consider as primary care practitioners may be counted if documentation that a well-care exam occurred is available in the medical record or administrative system before December 31 of the measurement year (i.e., entries made retroactive to the measurement year are not counted). The primary care practitioner does not have to be assigned to the member.*
- *The MCO may count services that occur over multiple visits toward this measure as long as all services occur within the time frame established in the measure.*
- *The MCO should refer to* Appendix 3 *for the definition of* primary care practitioner *and* OB/GYN practitioner. *This includes the use of nonphysician practitioners such as physician assistants and nurse practitioners.*
- *This measure is based on the CMS and American Academy of Pediatrics guidelines for EPSDT visits. The MCO should reference the American Academy of Pediatrics Guidelines for Health Supervision at www.aap.org and* Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents *(published by the National Center for Education in Maternal and Child Health) at www.Brightfutures.org for more detailed information on what constitutes a well-child visit.*

Data Elements for Reporting

An MCO that submits HEDIS data to NCQA must provide the following data elements.

Table AWC-1/2: Data Elements for Adolescent Well-Care Visits

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (administrative or hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓

Frequency of Selected Procedures (FSP)

SUMMARY OF CHANGES TO HEDIS 2007

- Added back surgery 65+ years to the commercial product line.
- Added back surgery procedure to the Medicare product line.
- Added ICD-9-Procedure codes 00.66, 00.70, 00.80, 36.06, 36.07 to Table FSP-A.
- Added HCPCS codes to Table FSP-A.

Description

This measure summarizes the number and rate of several frequently performed procedures that often show wide regional variation and have generated concern regarding potentially inappropriate utilization.

For Medicaid members, the MCO reports the absolute number of procedures and the number of procedures per 1,000 member months.

For commercial and Medicare members, the MCO reports the absolute number of procedures and the number of procedures per 1,000 member years.

Calculations

Product lines

Commercial: Table FSP-2E is constructed using Table FSP-2 as a template. Report the number of procedures and the rate of procedures per 1,000 member years, by age and sex.

Medicaid: Table FSP-1A reports the number of procedures and the rate of procedures per 1,000 member months, by age and sex. Report this measure for total Medicaid only because reporting by eligibility category will result in small numbers.

Medicare: Table FSP-3 reports the number of procedures and the rate of procedures per 1,000 member years, by age and sex.

Member months

Report all member months for the measurement year for members with the benefit. For more details, refer to *Specific Instructions for Use of Services Tables.*

Procedures

Procedures are identified using the specified codes in Table FSP-A. Report counts for the procedures as specified. Include all procedures, regardless of the site of care (for example, include myringotomies performed in ambulatory and inpatient settings). The number of procedures should be reported rather than the number of members who received the procedure. The MCO must not double count the same procedure. The two examples below illustrate scenarios that are counted as one procedure.

- Count one procedure if the date of service for two procedures is the same and both codes indicate coronary artery bypass graft (CABG).
- Count one procedure if the date of service for a procedure falls between the admission and discharge dates for an inpatient stay where the procedure was performed. For example, if a CABG was billed by a surgeon on March 4 of the measurement year and the facility bill shows a CABG for an admission that started on March 2 and lasted until March 7 of the measurement year, combine these to count one CABG.

Myringotomy Report myringotomy or myringotomy and adenoidectomy. Report toward both measures myringotomy and tonsillectomy occurring on the same date of service.

Report as two separate procedures two myringotomies performed on the same date of service by the same provider.

Do not report adenoidectomy performed alone.

Tonsillectomy Report tonsillectomy or tonsillectomy and adenoidectomy. Report toward both measures myringotomy and tonsillectomy occurring on the same date of service.

Do not report adenoidectomy performed alone.

Nonobstetric dilation and curettage (D&C) Report nonobstetric D&C.

Do not report obstetric D&C or termination of pregnancy D&C. Do not report ICD-9-CM codes 69.01 and 69.02 and CPT code 57820.

Do not report a nonobstetric D&C performed in conjunction with (i.e., on the same date of service as) a hysterectomy. These services are reported under hysterectomy.

Hysterectomy Report abdominal and vaginal hysterectomy separately.

Cholecystectomy Report open and closed (laparoscopic) cholecystectomy separately.

Back surgery Report all spinal fusion and disc surgery, including codes relating to laminectomy with and without disc removal.

Angioplasty (PTCA) Report all PTCAs performed separately. Do not report angioplasty or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the angioplasty or the cardiac catheterization rate; report only the CABG.

Cardiac catheterization Report all cardiac catheterizations performed separately. Do not report a cardiac catheterization performed in conjunction with (i.e., on the same date of service as) an angioplasty in the cardiac catheterization rate; report only the angioplasty.

Do not report angioplasty or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the angioplasty or the cardiac catheterization rate; report only the CABG.

Coronary artery bypass graft (CABG) Report each CABG only once for each date of service per patient, regardless of the number of arteries involved or the number or types of grafts involved.

Do not report angioplasty or cardiac catheterization performed in conjunction with (i.e., on the same date of service as) a CABG in the angioplasty or the cardiac catheterization rate; report only the CABG.

Prostatectomy Report the number of prostatectomies.

Reduction of fracture of femur Report the number of reductions of fracture of the femur.

Total hip replacement	Report the number of total hip replacements.
Total knee replacement	Report the number of total knee replacements.
Partial excision of large intestine	Report the number of partial excisions of the large intestine.
Carotid endarterectomy	Report the number of carotid endarterectomies.
Mastectomy	Report the number of mastectomies. Report bilateral mastectomy procedures as two procedures, even if performed on the same date.
Lumpectomy	Report the number of lumpectomies. Report multiple lumpectomies on the same date of service as one lumpectomy procedure per patient.

Note: *For Medicaid members, D&C and tonsillectomy, with or without adenoidectomy (excludes isolated adenoidectomy), were included because geographic variation in frequency was found. Myringotomy, with or without adenoidectomy (excludes isolated adenoidectomy), was also added because this procedure addresses otitis media, a condition common in children.*

Table FSP-A: Codes to Identify Selected Procedures

Description	CPT	HCPCS	ICD-9-CM Procedure	DRG
Myringotomy or myringotomy with adenoidectomy	69433, 69436		20.01	
Tonsillectomy or tonsillectomy with adenoidectomy	42820, 42821, 42825, 42826, 42860		28.2-28.4	
Nonobstetric dilation and curettage	58120		69.09	
Hysterectomy (abdominal)	51925, 58150, 58152, 58180, 58200, 58210, 58240, 58951, 58953, 58954, 58956, 59135, 59525		68.3, 68.4, 68.6, 68.8, 68.9	
Hysterectomy (vaginal)	58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290-58294, 58550, 58552-58554		68.5, 68.7	
Cholecystectomy (open)	47600, 47605, 47610, 47612, 47620		51.21, 51.22	
Cholecystectomy (closed/ laparoscopic)	47562-47564		51.23, 51.24	
Back surgery	22220, 22222, 22224, 22226, 22533, 22532, 22534, 22548-22585, 22590, 22595-22614, 22630, 22632, 22830 62263-62319, 63001-63017, 63020, 63030, 63035, 63040, 63042-63044, 63045-63048, 63050, 63051, 63055-63057, 63064, 63066, 63075-63078, 63081, 63082, 63085-63088, 63090, 63091, 63101-63103	S2348, S2350	03.02, 03.09, 80.50-80.52, 80.59, 81.0, 81.3, 81.6, 84.6	496-498, 519, 520, 546
Angioplasty (PTCA)	92980-92982, 92984, 92995, 92996		00.66, 36.01, 36.02, 36.05-36.07, 36.09	516-517, 526, 527, 555-558
Cardiac catheterization	93501, 93510, 93511, 93514, 93524, 93526-93529, 93539-93545		37.21-37.23, 88.55-88.57	104, 124, 125, 535, 536
Coronary artery bypass graft (CABG)	33510-33514, 33516-33519, 33521-33523, 33533-33536	S2205-S2209	36.1, 36.2	106, 107, 109, 547-550
Prostatectomy	52601, 52612, 52614, 52620, 52630, 52647, 52648, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866		60.21, 60.29, 60.3-60.5, 60.61, 60.62, 60.69	306, 307
Reduction of fracture of femur	27230, 27232, 27235, 27236, 27238, 27240, 27244-27246, 27248		79.05, 79.15, 79.25, 79.35	
Total hip replacement	27130, 27132, 27134		00.70, 00.80, 81.51, 81.53	
Total knee replacement	27446, 27447, 27486, 27487		81.54, 81.55	
Partial excision of large intestine	44140, 44141, 44143-44147, 44160, 44204-44208		45.7	
Carotid endarterectomy	34001, 35001, 35301, 35501, 35601, 35390		38.12	
Mastectomy	***Bilateral:*** 19180, 19182, 19200, 19220, 19240 with a modifier 50 code ***Unilateral:*** 19180, 19182, 19200, 19220, 19240 without a modifier 50 code		***Bilateral:*** 85.42, 85.44, 85.46, 85.48 ***Unilateral:*** 85.41, 85.43, 85.45, 85.47	***Unilateral:*** 257, 258
Lumpectomy	19120, 19125, 19126, 19160, 19162		85.2	259, 260, 262

Table FSP-1: Frequency of Selected Procedures: Medicaid

Member Months			
Age	**Male**	**Female**	**Total**
0-4			_____
0-9			_____
5-19			_____
10-19			_____
15-44		_____	
20-44	_____	_____	
30-64	_____		
45-64	_____	_____	

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Months
Myringotomy	0-4 5-19	Male and Female	_____ _____	_____ _____
Tonsillectomy	0-9 10-19	Male and Female	_____ _____	_____ _____
D&C	15-44 45-64	Female	_____ _____	_____ _____
Hysterectomy, abdominal	15-44 45-64	Female	_____ _____	_____ _____
Hysterectomy, vaginal	15-44 45-64	Female	_____ _____	_____ _____
Cholecystectomy, open	30-64	Male	_____	_____
	15-44 45-64	Female	_____ _____	_____ _____
Cholecystectomy, closed (laparoscopic)	30-64	Male	_____	_____
	15-44 45-64	Female	_____ _____	_____ _____
Back surgery	20-44	Male	_____	_____
		Female	_____	_____
	45-64	Male	_____	_____
		Female	_____	_____
Mastectomy	15-44 45-64	Female	_____ _____	_____ _____
Lumpectomy	15-44	Female	_____	_____

	45-64		_____	_____

Table FSP-2: Frequency of Selected Procedures: Commercial

Member Months			
Age	**Male**	**Female**	**Total**
0-4			_____
0-9			_____
5-19			_____
10-19			_____
15-44		_____	
20-44	_____	_____	
30-64	_____		
45-64	_____	_____	
65+	_____	_____	

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Myringotomy	0-4 5-19	Male and Female	_____ _____	_____ _____
Tonsillectomy	0-9 10-19	Male and Female	_____ _____	_____ _____
D&C	15-44 45-64	Female	_____ _____	_____ _____
Hysterectomy, abdominal	15-44 45-64 65+	Female	_____ _____ _____	_____ _____ _____
Hysterectomy, vaginal	15-44 45-64 65+	Female	_____ _____ _____	_____ _____ _____
Cholecystectomy, open	30-64	Male	_____	_____
	15-44 45-64	Female	_____ _____	_____ _____
	65+	Male	_____	_____
		Female	_____	_____
Cholecystectomy, closed (laparoscopic)	30-64	Male	_____	_____
	15-44 45-64	Female	_____ _____	_____ _____
	65+	Male	_____	_____
		Female	_____	_____

Table FSP-2: Frequency of Selected Procedures: Commercial *(continued)*

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Back surgery	20-44	Male		
		Female		
	45-64	Male		
		Female		
	65+	Male		
		Female		
PTCA	45-64	Male		
		Female		
	65+	Male		
		Female		
Cardiac catheterization	45-64	Male		
		Female		
	65+	Male		
		Female		
CABG	45-64	Male		
		Female		
	65+	Male		
		Female		
Prostatectomy	45-64 65+	Male		
Mastectomy	15-44 45-64 65+	Female		
Lumpectomy	15-44 45-64 65+	Female		

Table FSP-3: Frequency of Selected Procedures: Medicare

Member Months		
Age	**Male**	**Female**
<65	_____	_____
65-74	_____	_____
75-84	_____	_____
85+	_____	_____

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
CABG	<65	Male	_____	_____
		Female	_____	_____
	65-74	Male	_____	_____
		Female	_____	_____
	75-84	Male	_____	_____
		Female	_____	_____
	85+	Male	_____	_____
		Female	_____	_____
PTCA	<65	Male	_____	_____
		Female	_____	_____
	65-74	Male	_____	_____
		Female	_____	_____
	75-84	Male	_____	_____
		Female	_____	_____
	85+	Male	_____	_____
		Female	_____	_____

***Table FSP-3: Frequency of Selected Procedures: Medicare* (continued)**

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Cardiac catheterization	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Carotid endarterectomy	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Cholecystectomy, open	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Cholecystectomy, closed (laparoscopic)	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		

		Female	_____	_____

***Table FSP-3: Frequency of Selected Procedures: Medicare* (continued)**

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Back surgery	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Hysterectomy (abdominal)	<65	Female		
	65-74			
	75-84			
	85+			
Hysterectomy (vaginal)	<65	Female		
	65-74			
	75-84			
	85+			
Prostatectomy	<65	Male		
	65-74			
	75-84			
	85+			
Reduction of fracture of femur	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Total hip replacement	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		

		Female	_____	_____

***Table FSP-3: Frequency of Selected Procedures: Medicare* (continued)**

Procedure	Age	Sex	Number of Procedures	Procedures/ 1,000 Member Years
Total knee replacement	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Partial excision of large intestine	<65	Male		
		Female		
	65-74	Male		
		Female		
	75-84	Male		
		Female		
	85+	Male		
		Female		
Mastectomy	<65	Female		
	65-74			
	75-84			
	85+			
Lumpectomy	<65	Female		
	65-74			
	75-84			
	85+			

Inpatient Utilization—General Hospital/Acute Care (IPU)

SUMMARY OF CHANGES TO HEDIS 2007

- Deleted Occurrence code 10 from Table IPU-B.
- Removed "65–74 years" from the Maternity category (commercial, Medicaid, Medicare).

Description

This measure summarizes utilization of acute inpatient services in the following categories.

- Total services
- Medicine
- Surgery
- Maternity

Nonacute care, mental health and chemical dependency services and newborn care are excluded. Medical and surgical services are reported separately because the factors influencing utilization in these two categories vary. This method facilitates comparison between ambulatory surgery utilization (refer to the *Ambulatory Care* measure) and inpatient surgery utilization.

Calculations

Product lines

Medicaid: Tables IPU-1A through IPU-1D are constructed using Table IPU-1 as a template. Report discharges; discharges/1,000 member months; days; days/1,000 member months; and average length of stay (ALOS) for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare: Tables IPU-2, IPU-2E and IPU-3 are constructed using Table IPU-2/3 as a template. Report discharges; discharges/1,000 member years; days; days/1,000 member years; and ALOS for the members in the product line group that each table addresses.

Member months

Report all member months for the measurement year for members with the benefit. For more details, refer to the *Specific Instructions for Use of Services Tables.*

Discharges

Refer to the *Specific Instructions for Use of Services Tables* and the codes below to report discharges for total inpatient, maternity, surgery and medicine. Use codes in Table IPU-A to identify discharges.

Identify total discharges first, using Table IPU-A, and then separate discharges into maternity, surgery and medicine using Table IPU-B.

Table IPU-A: Codes to Identify Total Inpatient Discharges

ICD-9-CM Diagnosis		UB-92 Type of Bill
All principal diagnosis codes ***except***: • 290–316 • 960–979 with a secondary diagnosis of chemical dependency • V30–V39	***WITH***	11x, 12x, 41x, 42x, 84x

OR

DRGs
1-423, 439-455, 461, 463-471, 473, 475-520, 524-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code ***except***: • 290–316 • 960–979 with a secondary diagnosis of chemical dependency • V30–V39

Days

Count all days associated with the identified discharges. Refer to the *Specific Instructions for Use of Services Tables*. Report days for total inpatient, maternity, surgery and medicine.

ALOS

Refer to the *Specific Instructions for Use of Services Tables* for the formula. Calculate average length of stay for total inpatient, maternity, surgery and medicine.

Total inpatient acute care

Total inpatient excludes nonacute care, newborns, mental health and chemical dependency. The total should be the sum of the three categories (medicine, surgery and maternity) plus DRGs 469 (principal diagnosis invalid as discharge diagnosis) and 470 (ungroupable).

Maternity

Maternity includes all inpatient hospitalizations for maternity-related reasons, including abortions and antepartum stays. Include birthing center deliveries in this measure and count them as one day of stay.

Use the DRG codes, the ICD-9-CM principal diagnosis code or the UB-92 codes listed in Table IPU-B to identify maternity hospitalizations.

Surgery

DRGs are the preferred method to identify medical discharges. An MCO that uses ICD-9-CM codes must identify total inpatient, remove maternity-related discharges and include the remaining discharges accompanied by UB-92 Revenue code 036X.

Regardless of the method used to document surgeries, the MCO must verify how surgeries are identified.

Medicine

DRGs are the preferred method to identify medical discharges. An MCO that uses ICD-9-CM codes must identify total inpatient discharges, remove maternity related discharges and remove all discharges accompanied by UB-92 Revenue code 036X.

Medicine includes ICD-9-CM codes 960–979, indicating poisoning. Report claims with these principal diagnoses only for inpatient hospitalizations in which there was no secondary diagnosis of chemical dependency.

Report claims with principal diagnoses of chemical dependency in *Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay*.

Report newborn care separately in the *Discharge and Average Length of Stay, Newborn* measure; however, DRGs 385–391 have been included in this measure and should be reported under *Medicine* if the newborn care is rendered after the baby has been discharged home from delivery and is subsequently rehospitalized.

Table IPU-B: Codes to Identify Maternity, Surgery and Medicine Inpatient Discharges

Description	ICD-9-CM Diagnosis	UB-92 Revenue	UB-92 Type of Bill	DRG
Maternity	630-676, V24.0	0112, 0122, 0132, 0142, 0152, 0720-0722, 0724	84x	370-384
Surgery	Total – Maternity*	036x		1-8, 36-42, 49-63, 75-77, 103-109, 110-120, 146-171, 191-201, 209-234, 257-270, 285-293, 302-315, 334-345, 353-365, 392-394, 400-402, 406-408, 415, 439-443, 461, 468, 471, 476-486, 488, 491, 493-504, 506, 507, 512-520, 525-558
Medicine	Total – Maternity – Surgery			9-35, 43-48, 64-74, 78-102, 121-145, 172-190, 202-208, 235-256, 271-284, 294-301, 316-333, 346-352, 366-369, 385-391, 395-399, 403-405, 409-414, 416-423, 444-455, 463-467, 473, 475, 487, 489, 490, 492, 505, 508-511, 524, 559

* If the MCO uses ICD-9-CM Diagnosis codes to report this measure, all discharges reported in the Surgery group must be in conjunction with UB-92 Revenue code 036x.

Note

- *Gynecology and pediatric care should be included in the medicine and surgery categories as appropriate. Observation stays that result in an inpatient admission should be counted in the appropriate category in this measure.*
- *For this measure, maternity rates are reported (e.g., discharges/1,000 member years for commercial reporting, days/1,000 member months for Medicaid reporting) using total member years, males and females for commercial reporting and total member months, males and females for Medicaid reporting.*

Table IPU-1: Inpatient Utilization—General Hospital/Acute Care: Medicaid

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Age	Discharges	Discharges/ 1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Total Inpatient					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____
Medicine					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____

Age	Discharges	Discharges/ 1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Total:	_____	_____	_____	_____	_____

Table IPU-1: Inpatient Utilization—General Hospital/Acute Care: Medicaid *(continued)*

Age	Discharges	Discharges/ 1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
Surgery					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____
Maternity*					
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

***The maternity category is calculated using member months for members 10–74 years.

Table IPU-2/3: Inpatient Utilization—General Hospital/Acute Care: Commercial and Medicare (Reported Separately)

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Table IPU-2/3: Inpatient Utilization—General Hospital/Acute Care: Commercial and Medicare (Reported Separately) (continued)

Age	Discharges	Discharges/ 1,000 Member Years	Days	Days/1,000 Member Years	Average Length of Stay
Total Inpatient					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____
Medicine					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____
Surgery					
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Table IPU-2/3: Inpatient Utilization—General Hospital/Acute Care: Commercial and Medicare (Reported Separately) (continued)

Age	Discharges	Discharges/ 1,000 Member Years	Days	Days/1,000 Member Years	Average Length of Stay
Maternity					
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Ambulatory Care (AMB)

SUMMARY OF CHANGES TO HEDIS 2007

- Moved UB-92 Revenue code 0456 from Table AMB-A to Table AMB-B.
- Deleted UB-92 Type of Bill code 43x from Tables AMB-B, AMB-C and Table AMB-D.

Description

This measure summarizes utilization of ambulatory services in the following categories.

- Outpatient visits
- Emergency department (ED) visits
- Ambulatory surgery/procedures performed in hospital, outpatient facilities or freestanding surgical centers
- Observation room stays that result in discharge (observation room stays resulting in an inpatient admission are counted in the *Inpatient Utilization—General Hospital/Acute Care* measure)

Calculations

Product lines

Medicaid: Tables AMB-1A through AMB-1D are constructed using Table AMB-1 as a template.

Report outpatient visits; ED visits; ambulatory surgery/procedures; observation room stays; and the respective rates/1,000 member months for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare: Tables AMB-2, AMB-2E and AMB-3 are constructed using Table AMB-2/3 as a template.

Report outpatient visits; ED visits; ambulatory surgery/procedures, observation room stays; and the respective rates/1,000 member years for members in the product line group that each table addresses.

Member months

Report all member months for the measurement year for members with the benefit. For more details, refer to *Specific Instructions for Use of Services Tables.*

Outpatient visits (evaluation and management services)

This category reports face-to-face encounters between the practitioner and patient and provides a reasonable proxy for professional ambulatory encounters. It is neither a strict accounting of all ambulatory resources nor an effort to be all-inclusive.

Report services without regard to practitioner type, training or licensing.

Encourage detailed service reporting, even when the financial reimbursement arrangement does not require it, in order to facilitate comparability and complete reporting.

Include after-hours, nonemergency urgent care.

Include nursing home visits.

Include office-based surgical procedures (use the codes presented under the *Ambulatory Surgery/Procedures* section in this measure and include surgeries conducted at the practitioner's office).

Count each occurrence of the CPT codes listed in Table AMB-A if rendered by different practitioners (a given CPT code may count more than once on the same date of service if rendered by different practitioners).

Do not count mental health and chemical dependency services that meet any of the following criteria.

- Principal/first listed Diagnosis codes ICD-9-CM 290–316
- Principal/first listed Diagnosis codes ICD-9-CM 960–979. with a secondary diagnosis of chemical dependency
- CPT Procedure codes 90801–90899
- ICD-9-CM Procedure codes 94.26, 94.27 and 94.6

Table AMB-A: Codes to Identify Outpatient Visits

Description	CPT	UB-92 Revenue
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245	
Home services	99341-99350	
Prolonged services	99354-99355	
Comprehensive nursing facility assessments	99301-99303	
Subsequent nursing facility care	99311-99313	
Domiciliary, rest home or custodial care services	99321-99323, 99331-99333	
Preventive medicine	99381-99387, 99391-99397, 99401-99404, 99411-99412, 99420-99429	
Newborn care	99432	
Other evaluation and management services	99499	
Ophthalmology and optometry	92002-92014	
Clinic		051x
Freestanding clinic		052x
Professional fee, outpatient services		0982
Professional fees, clinic		0983

Note: *An MCO that does not use CPT codes must develop a method to count all face-to-face encounters with PCPs, specialists, nurse practitioners, nurses, physician assistants, ophthalmologist and optometrists.*

ED visits

This category measures use of ED services, which are included because they occasionally substitute for ambulatory clinic encounters.

While patient behavior is a factor in the decision to use an ED rather than a clinic or physician's office, the decision may be a result of insufficient access to primary care; therefore, trends in ED use are an important aspect of total utilization data.

Count once each visit to an ED that does not result in an inpatient stay, regardless of the intensity of care required during the stay or the length of stay. Count only one ED visit per date of service.

Count visits to urgent care centers under *Outpatient Visits*.

Note: *ED visits are identified by the codes in Table AMB-B.*

Do not count mental health and chemical dependency services that meet any of the following criteria.

- Principal/first listed Diagnosis codes ICD-9-CM 290–316
- Principal/first listed Diagnosis codes ICD-9-CM 960–979, with a secondary diagnosis of chemical dependency
- CPT Procedure codes 90801–90899
- ICD-9-CM Procedure codes 94.26, 94.27 and 94.6

Table AMB-B: Codes to Identify Emergency Department Visits

UB-92 Revenue	*AND*	UB-92 Type of Bill
045x, 0981		13x

OR

CPT	*AND*	POS
10040-69979		23

OR

CPT
99281-99285

Ambulatory surgery/ procedures

This is an important category to include in ambulatory reporting because many procedures formerly performed during an inpatient stay are routinely performed on an outpatient basis. Some hospitals have developed large ambulatory surgery centers and independent surgical centers have been built to accommodate this trend.

New technology makes it possible to perform complex surgery in an ambulatory setting and a growing number of procedures are performed at a physician's office; however, surgeries/procedures performed in physicians' offices are excluded from this category, which includes surgical procedures, scopics/lithotripsy and heart procedures.

Identify ambulatory surgery/procedure encounters using Option A (CMS 1500) or Option B (UB-92). Refer to Table AMB-C below for both options. CMS 1500 and CPT codes are the preferred methods for this measure; when necessary, the MCO should use both methods (i.e., CMS A 1500 and UB-92). The MCO must avoid double counting and report only ambulatory surgery/procedures performed at a hospital outpatient facility or at a freestanding surgery center. Do not report office-based surgeries/procedures in this category; report them under *Outpatient Visits.*

Count every *ambulatory surgery/procedures encounter,* which is one discrete service date for a specific member at a specific site (regardless of the number of services provided at that site on that day for that member).

Do not count claims with ED Revenue codes (Form Locator 42) of 45X in this category; report them under *Emergency Department Visits.*

Do not count mental health and chemical dependency services that meet any of the following criteria.

- Principal/first listed Diagnosis codes ICD-9-CM 290–316
- Principal/first listed Diagnosis codes ICD-9-CM 960–979, with a secondary diagnosis of chemical dependency
- CPT Procedure codes 90801–90899
- ICD-9-CM Procedure codes 94.26, 94.27 and 94.6

Option A: Use CMS 1500 codes in conjunction with CPT codes to identify ambulatory surgery/procedures.

Table AMB-C: Codes to Identify Ambulatory Surgery/Procedures

CPT		POS
All codes included in the CMS Ambulatory Surgical Center (ASC) Base Eligibility File and 92953, 92970, 92971, 92975, 92980, 92982, 92986, 92990, 92992, 92993, 92995, 92996, 93501-93536, 93600-93652	*AND*	22, 24

Note: *The CMS ASC Base Eligibility File is available through the Bureau of Data Management and Strategy at (877) 267-2323. MCOs should use ASC Base Eligibility File that was valid on December 31, 2006.*

Option B: Use UB-92 Type of Bill codes in conjunction with UB-92 Revenue codes, CPT codes and ICD-9-CM codes to identify ambulatory surgery/procedures.

ICD-9-CM Procedure		UB-92 Revenue		UB-92 Type of Bill
01.0-86.9, 88.4, 88.5, 98.5	*AND*	0320, 0321, 0323, 036x, 0480, 0481, 049x, 075x, 079x	*AND*	13x, 83x

Observation department stays

This category measures observation room stays that result in discharge of the patient. Observation room stays are used increasingly to determine if the condition of a patient necessitates inpatient admission. Trends in utilization of observation rooms are an important aspect of total utilization data.

This measure does not attempt to capture observation services exhaustively. Because current coding does not allow data to be obtained on comparable observation services from facility-based and professional claims, a more restrictive approach was chosen, recognizing that not all observation services will be captured but that reported data would be more comparable.

Count once each stay in an observation room that does not result in an inpatient stay, regardless of the intensity of care required during the stay or the length of time spent.

Do not count patients admitted to the hospital from the observation unit (whose observation unit stay is billed as inpatient). Do not count mental health and chemical dependency services that meet any of the following criteria.

- Principal/first listed Diagnosis codes ICD-9-CM 290–316
- Principal/first listed Diagnosis codes ICD-9-CM 960–979, with a secondary diagnosis of chemical dependency
- CPT Procedure codes 90801–90899
- ICD-9-CM Procedure codes 94.26, 94.27 and 94.6

Do not include claims with ED Revenue codes (Form Locator 42) of 45X from this category and report them under *Emergency Department Visits.* Report ED visits that result in an observation room stay under *Emergency Department Visits.*

Do not include claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321 or 323) from this category and report them under *Ambulatory Surgery/Procedures.*

Do not include UB-92 Revenue codes 0760 and 0769. Although some observation room stays are coded with these Revenue codes, other visits and services not classified as observation room stays would be captured.

Table AMB-D: Codes to Identify Observation Room Stays

UB-92 Revenue	*AND*	UB-92 Type of Bill
0762		13x

OR

CPT
99217-99220

Note: *For members with multiple ambulatory services falling in different categories on the same day, report each service that meets the criteria in the appropriate category.*

Table AMB-1: Ambulatory Care—Medicaid

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

	Outpatient Visits		Emergency Department Visits		Ambulatory Surgery/ Procedures		Observation Room Stays Resulting in Discharge	
Age	Visits	Visits/ 1,000 Member Months	Visits	Visits/ 1,000 Member Months	Procedures	Procedures/ 1,000 Member Months	Stays	Stays/ 1,000 Member Months
<1	_____	_____	_____	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	_____		_____		_____		_____	
Total:	_____	_____	_____	_____	_____	_____	_____	_____

Table AMB-2/3: Ambulatory Care—Commercial and Medicare (Report Separately)

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

	Outpatient Visits		Emergency Department Visits		Ambulatory Surgery/ Procedures		Observation Room Stays Resulting in Discharge	
Age	**Visits**	**Visits/ 1,000 Member Years**	**Visits**	**Visits/ 1,000 Member Years**	**Procedures**	**Procedures/ 1,000 Member Years**	**Stays**	**Stays/ 1,000 Member Years**
<1	_____	_____	_____	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____	_____	_____	_____
Unknown	_____		_____		_____		_____	
Total:	_____	_____	_____	_____	_____	_____	_____	_____

Inpatient Utilization—Nonacute Care (NON)

SUMMARY OF CHANGES TO HEDIS 2007

- No changes to this measure.

Description

This measure summarizes utilization of nonacute inpatient care in hospice, nursing home, rehabilitation, SNF, transitional care and respite. These data exclude services with a principal diagnosis of mental health and chemical dependency.

Calculations

Product lines

Medicaid: Construct Tables NON-1A through NON-1D using Table NON-1 as a template.

Report discharges; discharges/1,000 member months; days; days/1,000 member months; and ALOS for members in the Medicaid eligibility category that each table addresses.

Commercial and Medicare: Construct Tables NON-2, NON-2E and NON-3 using Table NON-2/3 as a template.

Report discharges; discharges/1,000 member years; days; days/1,000 member years; and ALOS for members in the product line group that each table addresses.

Member months

Report all member months for the measurement year for members with the benefit. For more details, refer to *Specific Instructions for Use of Services Tables.*

Discharges

Refer to *Specific Instructions for Use of Services Tables* and the codes listed in Table NON-A to report discharges for inpatient utilization.

Days

Count all days associated with the listed discharges. Refer to *Specific Instructions for Use of Services Tables* and the codes listed in Table NON-A to report days for inpatient utilization.

ALOS

Refer to *Specific Instructions for Use of Services Tables* and the codes listed in Table NON-A to report ALOS for the identified discharges.

Inpatient utilization

Use the codes in Table NON-A to identify nonacute care. Include data from any institution that provides long-term/specialty nonacute care. Do not count mental health and chemical dependency services that meet any of the following criteria.

- Principal/first listed Diagnosis codes ICD-9-CM 290–316
- Principal/first listed Diagnosis codes ICD-9-CM 960–979 with a secondary diagnosis of chemical dependency
- CPT Procedure codes 90801–90899
- ICD-9-CM Procedure codes 94.26, 94.27 and 94.6

Count inpatient nonacute stays with a principal diagnosis of mental retardation (ICD-9-CM codes 317–319).

Table NON-A: Codes to Identify Nonacute Care

Description	UB-92 Revenue	UB-92 Type of Bill	DRG
Hospice	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	81x, 82x	
SNF	019x	21x, 22x	
Hospital transitional care, swing bed or rehabilitation		18x	
Rehabilitation	0118, 0128, 0138, 0148, 0158		462
Respite	0655		
Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)			

Table NON-1: Inpatient Utilization—Nonacute Care: Medicaid

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Age	Discharges	Discharges/1,000 Member Months	Days	Days/1,000 Member Months	Average Length of Stay
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____

Table NON-2/3: Inpatient Utilization—Nonacute Care: Commercial and Medicare (Report Separately)

Age	Member Months
<1	_____
1-9	_____
10-19	_____
20-44	_____
45-64	_____
65-74	_____
75-84	_____
85+	_____
Unknown	_____
Total:	_____

Age	Discharges	Discharges/1,000 Member Years	Days	Days/1,000 Member Years	Average Length of Stay
<1	_____	_____	_____	_____	_____
1-9	_____	_____	_____	_____	_____
10-19	_____	_____	_____	_____	_____
20-44	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____
65-74	_____	_____	_____	_____	_____
75-84	_____	_____	_____	_____	_____
85+	_____	_____	_____	_____	_____
Unknown	_____		_____		_____
Total:	_____	_____	_____	_____	_____