Cost of Care

Specific Guidelines for Cost of Care Measures

Description

Relative Resource Use measures

HEDIS 2007 includes three new measures of relative resource use for members with specific chronic and acute conditions.

- Relative Resource Use for People With Diabetes
- Relative Resource Use for People With Asthma
- Relative Resource Use for People With Acute Low Back Pain

Also included in this section are three measures that will not be collected until HEDIS 2008.

- Relative Resource Use for People With Uncomplicated Hypertension
- Relative Resource Use for People With Cardiovascular Conditions
- Relative Resource Use for People With Chronic Obstructive Pulmonary Disease (COPD)

The measures are a standardized approach to measuring relative resource use. When evaluated with the corresponding quality of care measures, they provide more information about the *efficiency* or *value* of services rendered by a health plan. Relative Resource Use measures share the following features.

- They focus on high-cost conditions that have corresponding HEDIS Effectiveness of Care measures.
- They differentiate between unit price and utilization variation.
- They rely on a transparent risk-adjustment methodology similar to a proprietary risk-adjustment system.

Definitions

Major clinical conditions

Relative Resource Use measures evaluate six major clinical conditions. Members can be identified for more than one major clinical condition.

- Acute Low Back Pain
- Asthma
- Cardiovascular Conditions
- COPD
- Diabetes
- Uncomplicated Hypertension

Clinical category

A more specific identification of a member's condition. For each major clinical condition, assign a member to one clinical category based on the hierarchies listed in Table A. For example, for the major clinical condition of diabetes, assign the member to one clinical category using the following hierarchy: diabetes type 1 or diabetes type 2.

Comorbidity

The presence of one or more related disorders or diseases, in addition to a primary disease or major clinical condition. Major clinical conditions and categories are further stratified based on the presence of a relevant comorbid condition (e.g., cardiovascular conditions, diabetes, depression, hypertension, COPD, asthma, chronic renal failure).

Table A: Clinical Reporting Categories by Hierarchies and Comorbid Groups

Major Clinical Condition	Clinical Category	Comorbidity
Diabetes	Diabetes, type 1	With comorbidity
Diabetes	Diabetes, type 1	Without comorbidity
Diabetes	Diabetes, type 2	With comorbidity
Diabetes	Diabetes, type 2	Without comorbidity
Asthma	—	With comorbidity
Asthma	—	Without comorbidity
Acute Low Back Pain	—	Regardless of comorbidity status
Hypertension, uncomplicated	—	Exclude members with comorbidity
Cardiovascular	CHF	With comorbidity
Cardiovascular	CHF	Without comorbidity
Cardiovascular	AMI	With comorbidity
Cardiovascular	AMI	Without comorbidity
Cardiovascular	CAD	With comorbidity
Cardiovascular	CAD	Without comorbidity
Cardiovascular	Angina	With comorbidity
Cardiovascular	Angina	Without comorbidity
COPD	—	With comorbidity
COPD	—	Without comorbidity

Reporting categories

Full expansion of the major clinical conditions, clinical categories and comorbidities results in 18 member groups, or **clinical reporting categories,** as shown in Table A. Each Relative Resource Use measure collects and reports results for one or more reporting category.

Age and gender

Within the major clinical conditions, categories and comorbidities, members are further stratified by age and gender. Use the age as of the end of the continuous enrollment period to identify appropriate member cohort.

Member cohorts

The result of all categorizations described above is a **member cohort**. Within each major clinical condition (i.e., one RRU measure) a member may be in only one member cohort.

Dominant medical condition

Exclude from all Relative Resource Use measures members with the following dominant medical conditions.

- Active cancer
- Organ transplant
- ESRD
- HIV/AIDS

Identification of the dominant medical conditions is the same across all measures in this domain and is presented in detail in the *Relative Resource Use for People With Diabetes* measure.

Risk adjustment

A methodology that adjusts results based on differences in the mix of clinical conditions, age and gender in an MCO's member population. The following three attributes define an individual's member cohort and serve as the risk adjustment

basis for the measures.

1. Clinical condition
2. Presence of comorbidity for that condition
3. Age and gender

Risk adjusted peer amount

For each member cohort, NCQA compares the MCO's results with a risk-adjusted peer amount. Peer amounts represent what is expected from an MCO that has the same mix of members as other MCOs across cohorts within a major clinical category.

Standard price

Unit price per service representing standardized, allowed payment levels for provider services, including payer liability and member cost-sharing. Unit prices are calculated to represent data derived from a single source, using a single approach for classifying and pricing services. Pricing algorithms represent average service pricing levels for MCOs for the most recent period.

Standard prices support consistent comparison across all members, MCOs and geographic areas and protect individual MCO proprietary pricing and fee schedules. Methods and data used for deriving standard prices vary by service category.

Standard cost

The standard cost, or cost, used for these measures represents the standard price multiplied by the quantity of the service. Standard costs are aggregated across services and members to compute overall cost of care.

Service categories

Types of services a member may utilize; data are collected separately across service categories. All Relative Resource measures have the following service categories to report standard cost.

- Inpatient Facility
- Procedure and Surgery
- Evaluation and Management (E&M)
- Pharmacy

In addition, the following categories are used to report service frequency.

- Inpatient Discharges
- Emergency Department Discharges
- Observation Room Discharges

Some measures may collect utilization information for additional service categories (e.g., MRIs in the *Relative Resource Use for People With Acute Low Back Pain* measure).

Inpatient Facility Services Standard Price

For inpatient services provided by a facility, standard prices are assigned to each stay based on the standard per diem price provided on NCQA's Web site. MCOs use the length of stay and either DRG or ICD-9-CM codes to assign the appropriate standard price. (Refer to *Calculating Standard Units of Service and Total Standard Price:* Inpatient Facility.)

E&M Services; Procedure and Surgery Services (Professional) Standard Price

Standard prices for E&M and Procedures and Surgery Services (professional component) use a resource-based, relative value scale (RBRVS), which establishes consistent prices across a wide range of professional services, including those performed by different specialists and other professionals. Standard prices are provided on NCQA's Web site. (Refer to *Calculating Standard Units of Service and*

Total Standard Price: E&M; Surgery and Procedures).

Pharmacy Services Standard Price Standard prices for ambulatory prescriptions are based on an index of average wholesale prices (AWP). The standard price is listed per metric quantity for each NDC code. MCOs that do not capture the metric quantity for a prescription can assign a standard average price based on the average metric quantity typically prescribed for a particular NDC. Both the standard price per metric quantity and the standard average price are included in the standard price table provided on NCQA's Web site. (Refer to *Calculating Standard Units of Service and Total Standard Price:* Pharmacy Services.)

Note: *Medical supplies (e.g., syringes) are not included in these measures.*

Metric quantity For an ambulatory prescription, the quantity of medication supplied.

Overview

The measures for chronic conditions report a MCO's services over 12 months and calculate the total relative resource use for the eligible population. The measure pertaining to acute conditions *(Acute Low Back Pain)* calculates resource use related to the underlying condition only during a specified Episode Treatment Period.

The MCO identifies members for each major clinical condition and assigns them to member cohorts within a condition. The relevant medical and pharmacy services for these eligible members for the measurement year are identified. The MCO calculates total standard costs for each service category using a standard price table that NCQA provides; measure specifications list the services to be measured and the corresponding standard price. The MCO reports total standard costs for the eligible population across all services by member cohort for each *reporting category* and *service category*. In addition to standard cost, the MCO reports the frequency of the selected services. Reporting tables include member-month counts for the eligible population, stratified by member cohort: reporting category; age and gender; and pharmacy benefit status.

A member may be in more than one relative resource use measure or major clinical category (e.g., diabetes and cardiac disease); however, a member may be in only one member cohort within a major clinical condition.

Results are reported by MCOs to NCQA at the member cohort level. For each measure, total standard cost, utilization, and medical and pharmacy member months will be reported by member cohort. NCQA uses these stratifications to create risk-adjusted comparisons among health plans. Using the data submitted by all MCOs, NCQA estimates the observed and expected relative resource use amounts for each clinical condition for each MCO. Observed amounts represent the MCO's experience; expected amounts are based on regional or national norms after adjustments for the MCO's mix of conditions and members. Relative resource use (RRU) index amounts are calculated for each MCO based on the ratio of observed to expected amounts. Results can be assessed at an overall basis, across all members and major clinical conditions, by major clinical condition, or for a member cohort within a condition.

MCOs then may compare their observed amounts with expected amounts (e.g., national or regional). MCOs may choose to do additional analysis by using these methods to calculate their true observed costs for these conditions and services without adjusting for standard prices. True MCO cost information will not be submitted to or collected by NCQA.

Guidelines

1. **Members who switch product lines.** Assign MCO members to the product they are enrolled in on the last day of the continuous enrollment period as specified in each measure's eligible population criteria.

2. **Services provided during the measurement year.** Report information on services that occurred during the measurement year.

3. **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 for which the MCO has paid or expects to pay.

4. **Calculating member months.** For the Cost of Care measures, tables for reporting medical benefit and pharmacy benefit member months by age and gender category are provided. The MCO should complete the tables for all eligible members with the relevant benefit during the measurement year using the guidelines and formulas in the Use Of Services guidelines.

Pharmacy member months Pharmacy member months are the number of months during the measurement year that the member is covered by a pharmacy benefit. Refer to the Specific Guidelines for the Use of Services Measures for more details. For The MCO has the option to not count the months for a particular member, if the pharmacy benefit for that member was exhausted.

5. **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 that occurred during the measurement year or the Episode Treatment Period. All services should be reported under the member's age at of the end of the continuous enrollment period. Use the formulas and guidelines outlined below.

6. **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. All services should be reported under the member's age at of the end of the continuous enrollment period. The MCO should include all discharges that occurred during the measurement year or the Episode Treatment Period. Use the guidelines and formulas outlined below.

7. **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).

8. **Counting multiple services**. In general, if a member receives the same service or procedure at two different times (e.g., CABG procedures six months apart), count them as two procedures.

Services for pricing Count *all* services billed. For example, if a surgeon submits a bill for professional charges and a hospital submits a separate bill pertaining to the same surgical episode with the same date of service, each should be included in the appropriate service category (*Surgery* and *Inpatient Facility*, respectively).

Services for frequency For inpatient discharges, ED visits and observation room stays, count discharges, not the frequency of procedure codes billed. For example, if for one inpatient stay with a discharge, a surgeon submits a bill for professional charges and a hospital submits a separate bill pertaining to the same surgical episode with the same date of service, count only one inpatient discharge.

9. **Counting transfers** Follow the Use of Service Guidelines.

Mental health and chemical dependency transfers Follow the Use of Service Guidelines.

10. **Discharges** Follow the Use of Service Guidelines.

11. **Calculating inpatient services length of stay.** The MCO should use the formulas below to report length of stay

Length of stay (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.*

Calculating Service Frequency

Step 1 Identify all services rendered during the measurement year or the Episode Treatment Period for the eligible population.

Step 2 Match the eligible populations' services to the codes provided in the specifications. The categories reported are:

- Inpatient Discharges
- Emergency Department Visits
- Observation Room Stays
- Other condition specific category (e.g., MRI).

The codes used to report the first three categories are similar to the Use of Services *Inpatient Utilization-General Hospital/Acute Care*, *Inpatient Utilization-Nonacute* Care and the *Ambulatory Care* measures.

Step 3 Count the unique services rendered to each eligible member in each utilization category for each clinical category. See guidelines above for calculating unique services.

Step 4 Aggregate and report by MCO the service frequencies at the member cohort level.

Calculating Standard Price and Cost

Relative Resource Use measures use NCQA's standardized prices. The MCO does not report prices based on its contracts and fee schedules; it applies a standard price to each service, multiplies it by the number of services and reports the resulting standard cost. Consistent standard prices protect the plan's proprietary fee schedules and contracts and support measure comparison across plans and across regions without requiring adjustments for the levels of service payments.

Download the Standard Price Table (SPT) for each service category from NCQA's Web site (www.ncqa.org). (Refer to SPT examples.) This includes:

- SPT-INP-DRG
- SPT-INP-ADSC
- SPT-EM
- SPT-Surg-Proc
- SPT-Pharm.

The SPT tables contain the service codes used for the total standard cost estimation and their respective standard unit price. The MCO applies the SPT tables to all services in each service category using the following steps. Refer to measure specifications for additional instructions.

Step 1 Identify eligible members for each clinical category and categorize into the appropriate member cohort.

Step 2 For the eligible members, identify the place of service: Inpatient Facility, E&M, Surgery and Procedure and Pharmacy services for each service category.

- *Inpatient Facility* (services provided by a facility during an inpatient stay, including room and board and ancillary services)
- *E&M* (inpatient visits, office visits, consultations and other services)
- *Surgery and Procedures* (inpatient and outpatient procedures)
- *Pharmacy* (ambulatory prescription drug services included in a member's pharmacy benefit)

Step 4 Multiply the standard price by each unit of service to compute a standard cost for the service. See each service categories respective instructions for *Calculating Standard Units of Service and Total Standard Cost*.

Step 5 Within each major clinical condition (or RRU measure) aggregate or sum each eligible member's total standard cost within each service category.

Step 6 Within each service category if a member's total standard cost exceeds the service category "cap" amount, then truncate the member's total standard cost as listed in Table B: Identifying Service Category's Truncation Amounts. For example, if an eligible member's total inpatient facility standard cost was $97,000 during the measurement year, report the member's total inpatient standard cost as $75,000.

Table B: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
E&M	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: *Do not exclude members who exceed the capped amount.*

Step 7 Aggregate and report the eligible population's total standard cost at the member cohort level.

Methods used to identify the unit of service and assign standard unit prices vary by service category. Steps required for each category are described below.

Calculating Standard Units of Service and Total Standard Cost: Inpatient Facility

Step 1 Define a single, unique record describing the member's inpatient stay.

Step 2 Compute the LOS in days.

Step 3 Assign the length of stay to the appropriate LOS group using Table C: Length of Stay Group using the ranges listed.

Table C: Length of Stay Group

LOS (days)	LOS GRP
1	A
2	B
3-4	C
5-6	D
7-8	E
9-15	F
16 or more	G

Step 4 Download the appropriate Standard Price Tables for inpatient facility services from the NCQA Web site.

A different approach is used to determine standard costs for the inpatient stay depending on whether a supported DRG methodology has been assigned to the stay. The DRG methodologies supported by NCQA for this measure include CMS, AP-DRG, and APS-DRG.

If supported DRGs are consistently captured for the confinement or inpatient stays the MCO should use the methods described in steps 5a and 6a. If supported DRGs are not consistently captured health plans should follow steps 5b, 6b, 7b and 8b.

Step 5a Download the SPT-INP-DRG Table (refer to the *Example* Table SPT-INP-DRG).

Step 6a Multiply the inpatient LOS by the standard price to compute the standard cost for the stay.

For example, using the example table provided if a member with a DRG code for AMI (121) has an inpatient LOS of 8 days then the LOS Group is E and the total per diem standard cost for this visit would be:

8 x $1,850 = $14,800

Note: *These standard prices are only an example and may not reflect the standard price assigned to AMI DRG 121.*

Example: **Table SPT-INP-DRG—Inpatient Facility Services**

DRG	LOS GRP	Per Diem Std Unit Price ($)
121	A	6,400.00
121	B	3,400.00
121	C	3,100.00
121	D	2,950.00
121	E	1,850.00
121	F	1,825.00
121	G	1,775.00

Step 5b If a supported DRG is not available, create an Aggregate Diagnostic Service category (ADSC) for the inpatient stay using the principal discharge diagnosis (ICD-9-CM). To assign ADSC, download the ADSC-Table from NCQA's Web site. The table includes a list of each ICD-9-CM code and its respective diagnostic category (ADSC). Match the principal ICD-9-CM discharge diagnosis to an ADSC.

Step 6b Determine whether the inpatient stay is acute or nonacute. Nonacute stays include nursing home, skilled nursing facility (SNF) and rehabilitation (plans may use the *Inpatient-Nonacute Care* measure to identify nonacute stays). If the stay meets criteria, designate it as non-acute; all other inpatient stays are defined as acute.

Note: *The NCQA SPT-INP-ADSC table assigns the Acute field a value of "1" if the discharge was from an acute inpatient facility and a value of "0" if it is a discharge from a nonacute facility.*

Step 7b Determine whether during the inpatient stay the eligible member underwent a major surgery. Identify major surgeries by downloading the list of codes from the NCQA Web site (Maj-Surg-Table). Flag eligible members if one of the procedures codes listed in the Maj-Surg-Table is present from any provider during the time period defined by the admission and discharge dates for the inpatient stay.

Note: *The NCQA SPT-INP-ADSC table assigns the field MAJSURG a value of "1" to indicate the standard price when a major surgery is identified and a value of "0" if no major surgery is identified during the member's inpatient stay.*

Step 8b Multiply the length of stay for the inpatient confinement by the per diem standard price to compute the standard cost for the stay. For example, using the *Example* table above, an eligible member with an inpatient admission with a primary discharge diagnosis that is mapped to ADSC "Cardiovascular—A" and which has the following characteristics:

- LOS of 5 days (LOS GRP = D),
- A major surgery event during this stay, ***and***
- The inpatient stay was in an acute care facility

has a total inpatient or per diem standard cost of 5 x $4,450 = $22,250.

Example: **Table SPT-INP-ADSC—Inpatient Facility Services**

ADSC	MAJSURG	ACUTE	LOS GRP	Per Diem Std Unit Price ($)
Cardiovascular—A	No	Yes	A	6,400.00
Cardiovascular—A	No	Yes	B	3,400.00
Cardiovascular—A	No	Yes	C	3,100.00
Cardiovascular—A	No	Yes	D	2,950.00
Cardiovascular—A	No	Yes	E	1,850.00
Cardiovascular—A	No	Yes	F	1,825.00
Cardiovascular—A	No	Yes	G	1,775.00
Cardiovascular—A	Yes	Yes	A	7,700.00
Cardiovascular—A	Yes	Yes	B	5,500.00
Cardiovascular—A	Yes	Yes	C	4,900.00
Cardiovascular—A	Yes	Yes	D	4,450.00
Cardiovascular—A	Yes	Yes	E	4,000.00
Cardiovascular—A	Yes	Yes	F	3,700.00
Cardiovascular—A	Yes	Yes	G	3,400.00
Cardiovascular—A	No	No	A	XX
Cardiovascular—A	No	No	B	XX
Cardiovascular—A	No	No	C	XX
Cardiovascular—A	No	No	D	XX
Cardiovascular—A	No	No	E	XX
Cardiovascular—A	No	No	F	XX
Cardiovascular—A	No	No	G	XX
Cardiovascular—A	Yes	No	A	XX
Cardiovascular—A	Yes	No	B	XX
Cardiovascular—A	Yes	No	C	XX
Cardiovascular—A	Yes	No	D	XX
Cardiovascular—A	Yes	No	E	XX
Cardiovascular—A	Yes	No	F	XX
Cardiovascular—A	Yes	No	G	XX

Calculating Standard Units of Service and Total Standard Cost: E&M

Step 1 Identify each distinct E&M service for the eligible members that occurred during the measurement year.

Step 2 Download the appropriate Standard Price Tables (SPT-EM) for E&M services from the NCQA Web site. (Refer to the *Example* table above.)

The E&M procedure codes used for these measures are listed in Table SPT-EM and include the following.

- Office or Other Outpatient Services (CPT 99201–99215)
- Hospital Observation Services (CPT 99217–99210)
- Hospital Inpatient Services (CPT 99221–99239)

- Consultations (CPT 99241–99275)
- Critical Care and Intensive Care Services (CPT 99289–99298)
- Nursing Facility, Domiciliary and Home Services (CPT 99301–99350)
- Case Management Services and Care Plan Oversight Services (CPT 99361–99380)
- Preventive Medicine Services (CPT 99381–99429)
- Newborn Care (CPT 99431–99440)
- Other E&M (CPT 99450–99456, 99354–99357)

Step 3 Match each unique E&M service for the eligible members to the CPT codes listed in the SPT-EM table and assign the standard price to the E&M service.

Step 4 Sum the prices across the unique E&M services to obtain the total cost. For example, using the *Example* table below, if an eligible member had two 99201, three 99211 and one 99215 E&M codes during the measurement year, the total E&M standard cost would be calculated as follows.

Eligible Member's E&M Visits	NCQA Standard Price ($)
99201	37.50
99201	37.50
99211	22.00
99211	22.00
99211	22.00
99215	123.50
Total cost:	**264.50**

Example: Table SPT-EM E&M Services

PROCCODE	Description	Standard Unit Price ($)
99201	Office/outpatient visit, new	37.50
99202	Office/outpatient visit, new	67.00
99203	Office/outpatient visit, new	99.25
99204	Office/outpatient visit, new	140.25
99205	Office/outpatient visit, new	178.00
99211	Office/outpatient visit, est	22.00
99212	Office/outpatient visit, est	39.25
99213	Office/outpatient visit, est	54.50
99214	Office/outpatient visit, est	85.00
99215	Office/outpatient visit, est	123.50

Calculating Standard Units of Service and Total Standard Cost: Surgery and Procedures

Step 1 Identify all unique surgery and procedural services for the eligible members provided by physicians and other professional providers during the measurement year.

The valid procedure codes for use in selecting these services are listed in Table SPT-Surg-Proc Table included on the NCQA Web site.

Step 2 Identify modifier codes. Procedural modifiers are sometimes used in documenting a professional service. The standard price varies for some types of procedural modifiers; as a result, these modifiers are used in combination with the procedure code to match to the appropriate row on the standard pricing table. All other modifiers should be set to blank. Use the following modifiers only to adjust standard prices.

- 50 = Bilateral Service
- 51 = Multiple Surgery
- 52 = Reduced Service
- 54 = Surgical Care Only
- 55 = Post-Surgical Care Only
- 56 = Pre-Op Surgical Care Only
- 78 = Return to Operating Room
- 62 = Two Surgeons
- 80–82 = Assistant at Surgery

Step 3 Identify services, surgery or procedure, provided in an inpatient facility (acute or nonacute). Inpatient services are assigned different unit prices. In the tables provided by NCQA services provided in an inpatient setting are assigned a value of 1 in the POS field, all other services are assigned a value of 0.

Step 4 Download the Standard Price Tables (SPT-Proc) for procedure and surgery services from the NCQA Web site. (See *Example* Table SPT-Proc Surgery and Procedural Services.)

Step 5 Match each unique procedure code, along with the appropriate modifier and POS for the service to obtain the assigned standard price.

Step 6 Sum the standard prices across the procedure and surgery services to calculate the total cost. For example, if an eligible member underwent a removal of spinal lamina surgery and CPT codes 63047 and 63047.80 were billed, and then later the member underwent additional back surgery and CPT code 63030 was billed, the total surgery and procedure standard cost would be calculated as follows.

Eligible Member's Procedures or Surgery	NCQA Standard Price ($)
63047	2,310.00
63047.80	370.00
63030	1,925.00
Total cost:	**4,605.00**

Example: Table SPT-Proc Surgery and Procedural Services

PROCCODE	Modifier	POS_I	Description	Standard Unit Price ($)
63030		1	Low back disk surgery	1,925.00
63035		1	Spinal disk surgery add-on	450.00
63040		1	Laminotomy, single cervical	2,900.00
63042		1	Laminotomy, single lumbar	2,730.00
63044		1	Laminotomy, additional lumbar	460.00
63045		1	Removal of spinal lamina	2,570.00
63047		1	Removal of spinal lamina	2,310.00
63047	.80	1	Removal of spinal lamina	370.00

Calculating Standard Units of Service and Total Standard Cost: Pharmacy Services

Step 1 For the eligible members identify all ambulatory prescriptions dispensed (pharmacy services) during the measurement year.

Step 2 Identify the NDC code and the metric quantity (if available) for each prescription. The metric quantity represents the standard unit for these calculations. MCOs that do not capture the metric quantity dispensed may use the average unit price listed. MCOs must select one approach and use it consistently.

Step 3 Download the SPT-PH from the NCQA Web site. The table includes:

- The NDC code
- A standard unit price per metric quantity
- An average standard unit price (based on average metric quantity).

Step 4 Match each NDC code to the appropriate row in Table SPT-PHARM. (Refer to the *Example* table below.)

Step 5 If the metric quantity is available, for each prescription multiply the metric quantity dispensed by the standard price per metric quantity (*Std. Unit Price per Metric Quantity [$]*).

Step 6 If the metric quantity is unavailable, for each prescription dispensing event use the average standard unit price (*Average Std Unit Price [$]*).

Step 7 Sum the unit prices across the unique prescription dispensing events. For example, if an eligible member had two prescriptions for antibiotics (NDC 11111111111), one with a metric quantity of 8 and another with a metric quantity of 12; one for congestion (22222222222) with a metric quantity of 10; and three for allergies (66666666666), with two having a metric quantity of 8 and one a metric quantity of 15, the total standard pharmacy services cost is:

Eligible Member's Prescriptions	Metric Quantity Prescribed	NCQA Standard Unit Price per Metric Quantity	NCQA Standard Unit Price ($)
11111111111	8	10.00	80.00
11111111111	12	10.00	120.00
22222222222	10	20.00	200.00
66666666666	8	30.00	240.00
66666666666	8	30.00	240.00

66666666666	15	30.00	450.00
Total cost:	—	—	**1,330.00**

If the metric quantity is unavailable, using the example above, the total standard pharmacy services cost for this eligible member is:

Eligible Member's Prescriptions	Metric Quantity Prescribed	NCQA Average Standard Unit Price ($)
11111111111	NA	$100.00
11111111111	NA	$100.00
22222222222	NA	$200.00
66666666666	NA	$300.00
66666666666	NA	$300.00
66666666666	NA	$300.00
Total cost:	—	**$1,300.00**

Note: *Use only services rendered to an eligible member that are listed in NCQA's Standard Price and Tables.*

Example: **Table SPT-PHARM Pharmacy Services**

NDC	Std Unit Price per Metric Quantity ($)	Average Std Unit Price ($)
11111111111	10.00	100.00
22222222222	20.00	200.00
33333333333	30.00	300.00
44444444444	10.00	50.00
55555555555	20.00	100.00
66666666666	30.00	300.00

Applying MCO Fee Schedule and Calculating Observed MCO Cost

NCQA collects data that apply the standardized prices only; however, MCOs may use the same methods described above for select major clinical conditions to calculate the observed true costs based on unit prices or fee schedule. For these calculations, MCOs should use the *allowed payment amount* for services identified for each eligible member and sum them within each service category or member cohort. A total sum may also be calculated for the major clinical condition.

The MCO does not report to NCQA prices based on its contracts and fee schedules, but it may share observed total cost information with purchasers alongside NCQA reported and calculated Relative Resource Use results.

Relative Resource Use Results

Using the data submitted by all MCOs, NCQA will estimate the observed and expected relative resource use amounts for each clinical condition for each MCO. Observed amounts represent the MCO's own experience; expected amounts are based on regional or national norms after adjustments for the MCO's mix of conditions and members. Relative resource use (RRU) index amounts are calculated for each MCO based on the ratio of observed to expected amounts. Results can be assessed at an overall basis, across all members and major clinical conditions, by service category, or for a member cohort within a condition.

NCQA uses the following approach and formulas to compute the RRU index. This description is for the RRU index for standard costs; similar logic is employed for the selected utilization frequency measures.

- **C** = MCO standard costs
- **i** Indexes eligible members
- **s** Indexes service categories
- **m** Indexes member cohorts
- **p** Indexes reporting organization (MCO)

Standard costs are reported by service category across all eligible members within a member cohort. Member cohorts are defined by clinical reporting category (e.g., Type 1 Diabetes With Comorbidity) and age and gender group. Following the assignment of standard price to services provided to eligible members, the MCO sums standard costs across eligible members for each member cohort to compute total costs for a service category (for Plan P).

$$C_{s,m,p} = \sum_i C_{i,s,m,p}$$

In addition to standard costs, MCOs report total member months (Totmm) and pharmacy member months (Rxmm) for each member cohort.

$$Totmm_{m,p} = \sum_i Totmm_{i,m,p}$$

$$Rxmm_{m,p} = \sum_i Rxmm_{i,m,p}$$

NCQA collects this information for all MCOs. The data is pooled across organizations in a "peer group" and used to compute normative benchmarks that can be used to estimate expected standard costs for each organization.

Peer benchmarks are created at the per eligible member per month (PMPM) level; standard cost benchmarks (BenchC) are created for each member cohort and service category. For example, for standard costs, NCQA first aggregates costs across plans in a peer group:

$$BenchC_{s,m} = \sum_p C_{s,m,p}$$

Total and pharmacy member months are also summed:

$$BenchTotmm_m = \sum_p Totmm_{m,p}$$

$$BenchRxmm_m = \sum_p Rxmm_{m,p}$$

Note: *In these calculations, only the values for p included in the peer benchmark group are used.*

For nonpharmacy service categories, the benchmark PMPM for a peer group is:

$$BenchCpmpm_{s,m} = BenchC_{s,m}/BenchTotmm_m$$

For the pharmacy service categories, the benchmark PMPM for a peer group is:

$$BenchCpmpm_{s,m} = BenchC_{s,m}/BenchRxmm_m$$

To compute expected amounts for standard costs, values are computed as follows.

For nonpharmacy services:

$$E(C_{s,m,p}) = BenchCpmpm_{s,m} * Totmm_{m,p}$$

For pharmacy services:

$$E(C_{s,m,p}) = BenchCpmpm_{s,m} * Rxmm_{m,p}$$

At this point, expected and actual values can be compared and an RRU index or ratio calculated for each combination of service category and member cohort. The actual expected amount can also be aggregated and an RRU ratio calculated at any level. An overall ratio across all clinical reporting categories and member cohorts would be (for MCO p):

$$RRU_p = \sum_s \sum_m C_{s,m} / \sum_s \sum_m E(C_{s,m}).$$

After calculating RRU findings, NCQA provides the MCOs with their relative resource index score at the service category and major clinical condition level.

- A score of 1.00 indicates that the observed amounts for standard costs or utilization were are equal to the expected amounts
- A score >1.00 indicates that the observed amounts for standard costs or utilization are greater than the expected amounts
- A score <1.00 indicates that the observed amounts for standard costs or utilization are lower than the expected amounts

For example, a MCO whose observed-to-expected calculation is 1.10 for pharmacy services in its *Relative Resource Use for People With Diabetes* (RDI) has a total standard cost for pharmacy services for RDI that is 10 percent higher than expected total pharmacy services cost.

Relative Resource Use for People With Diabetes (RDI)

SUMMARY OF CHANGES TO HEDIS 2007

- First-year measure.

Description

This measure reports the relative resource use, during the measurement year, for members with diabetes. Health plans calculate and report the eligible populations' total standard cost (based on NCQA provided standard price tables) and utilization by member cohort as instructed in the specification. Upon receiving and based on all health plan data NCQA will calculate *expected* (or average) total standard cost and utilization results (regional and national), after which health plans will receive their observed-to-expected ratio (or relative resource use ratio) for the clinical condition and each service category. When evaluated with the HEDIS *Comprehensive Diabetes Care (CDC)* measure, the relative resource use ratios provide a better understanding of the efficiency or value of services rendered by the MCO.

See the Cost of Care Guidelines for definitions, methods to apply standard price to services and calculation processes.

Eligible Population

Note: *The eligible population is the same as the CDC measure with additional exclusions; it is further stratified into clinical categories (e.g. diabetes type 1 or type 2) in the Categorization of the Eligible Population section.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 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 measurement year. To determine continuous enrollment for a Medicaid beneficiary 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	Enrolled as of December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Two methods are provided to identify diabetic members: pharmacy data and claims/encounter data. The MCO must use both methods to identify the eligible population; however, a member only needs to be identified in one method to be included in the measure. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year. *Pharmacy data.* Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Refer to Table CDC-A.

Claim/encounter data. Members who had two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. The MCO may count services that occur over both years.

Use the codes in Table CDC-B to identify diabetes diagnosis with ambulatory or nonacute inpatient and acute inpatient or ED encounters.

Exclusions *(optional)*

Note: *MCOs that choose to apply the optional exclusions for the Comprehensive Diabetes Care measure* must *apply the optional exclusion for the Relative Resource Use for People With Diabetes measure.*

- Exclude members with a diagnosis of polycystic ovaries who did not have any face-to-face encounters with the diagnosis of diabetes, in any setting, during the measurement year or year prior to the measurement year. Diagnosis of polycystic ovaries can occur at any time in the member's history, but must have occurred by December 31 of the measurement year. Use the codes in Table CDC-B to identify a diagnosis of diabetes and the ICD-9 codes in CDC-L to identify a diagnosis of polycystic ovaries.
- Exclude any members with gestational diabetes or steroid-induced diabetes, who did not have any face-to-face encounters with the diagnosis of diabetes (in any setting), during the measurement year or year prior to the measurement year. Diagnosis of gestational diabetes or steroid-induced diabetes can occur during the measurement year or the year prior to the measurement year, but must have occurred by December 31 of the measurement year. Use the codes in Table CDC-B to identify a diagnosis of diabetes and the codes in CDC-L to identify gestational diabetes and steroid-induced diabetes.

Exclusions *(required)*

- Exclude from the eligible population members identified as having one or more of the following dominant conditions during the measurement year.
  - Active cancer
  - Organ transplant
  - ESRD
  - HIV/AIDS
- *For active cancer and ESRD,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a diagnosis code and with a procedure or revenue code listed in table RDI-A and RDI-B.
- *For organ transplant,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a procedure or revenue code listed in table RDI-C.
- *For HIV/AIDS,* exclude members who had at least two face-to-face encounters with different dates of service in an ambulatory or nonacute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year with a diagnosis code listed in tables RDI- D. Use the codes in Table RDI-E to identify the setting of care.

Table RDI-A: Codes to Identify Active Cancer Treatment

Description	ICD-9-CM Diagnosis
Cancer	140-208, 230-239

WITH

Description	CPT	ICD-9-CM Procedure	UB-92 Revenue
Treatment	38230, 38240-38242, 77261-77799, 79000-79999, 96400-96549	41.0, 41.91, 92.2	028x, 033x, 0342, 0344, 0973

Table RDI-B: Codes to Identify ESRD

Description	CPT	HCPCS	ICD-9-CM Diagnosis	ICD-9-CM Procedure	UB-92 Revenue	DRG
ESRD (including renal dialysis)	36145, 36800-36821, 36831-36833, 90919-90921, 90923-90925, 90935, 90937, 90939, 90940, 90945, 90947, 90989, 90993, 90997, 90999, 99512	G0257, G0311-G0319, G0321-G0323, G0325-G0327, S9339	585.5, 585.6, V42.0, V45.1, V56	38.95, 39.27, 39.42, 39.43, 39.53, 39.93, 39.94, 39.95, 54.98	080x, 082x-085x, 088x	317

Table RDI-C: Codes to Identify Organ Transplant

Description	CPT	HCPCS	ICD-9-CM Procedure	UB-92 Revenue
Organ transplant	32850-32856, 33930-33945, 44132-44137, 44715-44721, 47133-47147, 48160, 48550-48556, 50300-50380	S2152, S2053-S2055, S2060, S2061, S2065	33.5, 33.6, 37.5, 41.94, 46.97, 50.5, 52.8, 55.6	0362, 0367, 0810-0813, 0819

Table RDI-D: Codes to Identify HIV

Description	ICD-9-CM Diagnosis
HIV	042

Table RDI-E: Codes to Identify Inpatient or Outpatient Care Using Claim/Encounter Data

Description	CPT	UB-92 Revenue
Outpatient	92002, 92004, 92012, 92014, 98925-98929, 98940-98942, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99420, 99429, 99455, 99456, 99499	051x, 052x, 057x-059x, 077x, 082x-085x, 088x, 0982, 0983
Nonacute inpatient	99301-99313, 99315, 99316, 99318, 99321-99328, 99331-99337	0118, 0128, 0138, 0148, 0158, 019x, 055x, 066x
Acute inpatient	99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99261-99263, 99291	010x, 0110-0114, 0119, 0120-0124, 0129, 0130-0134, 0139, 0140-0144, 0149, 0150-0154, 0159,

		016x, 020x-022x, 072x, 080x, 0987
ED	99281-99285	045x, 0981

Categorizations of Eligible Population

Major clinical condition

Diabetes

Clinical categories

1. Diabetes Type 1
2. Diabetes Type 2

Count members in only one clinical category. All members are counted as diabetes type 2 unless they are identified as having type 1 diabetes. Members are identified as having type 1 diabetes if during the measurement year or year prior they have at least two face-to-face encounters with different dates of service in any setting with a diagnosis of type 1 diabetes. Those members who only have pharmacy data and do not have any claims data with a diagnosis of diabetes during the measurement year or year prior should be included in the diabetes type 2 clinical category. The MCO may count services that occur over both years. Use Table RDI-F to identify type 1 diabetes.

Table RDI-F: Codes to Identify Type 1 Diabetes

Description	ICD-9-CM Diagnosis
Diabetes type I	250.x1, 250.x3

Comorbid categorization

Members in the eligible population with evidence of asthma, cardiovascular conditions, COPD, depression, hypertension or chronic kidney disease are identified to be "with comorbidity" for the measure. The MCO must use all methods to identify comorbid status; however, once a member meets the criteria for one of the comorbid conditions, the MCO does not need to verify if the member has any of the remaining comorbid conditions. Follow the instructions for each comorbid condition.

Asthma

Step 1 Identify members as having persistent asthma who met at least one of the four criteria below during the measurement year or the year prior to the measurement year.

- At least one ED visit (Tables ASM-A and ASM-B), with asthma as the principal diagnosis
- At least one acute inpatient discharge (Table ASM-A and Table ASM-B), with asthma as the principal diagnosis
- At least four outpatient asthma visits (Table ASM-A and Table ASM-B), with asthma as a listed diagnosis and at least two asthma medication dispensing events (Table ASM-C)
- At least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions) (Table ASM-C)

Step 2 For a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the member must:

- Meet any of the other three criteria in step 1 in the same year as the leukotriene modifier, ***or***
- Have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Cardiovascular conditions

Members are identified for cardiovascular condition comorbidity in one of two ways: event or diagnosis occurring during the measurement year or year prior to the measurement year. The MCO must use both criteria to identify comorbidity status.

- *Event*. Discharged alive for AMI, CABG or PTCA. Use the codes listed in Table CMC-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).
- *Diagnosis*. At least one outpatient/nonacute inpatient or acute inpatient/ED visit with a diagnosis of IVD (Table CMC-B).

COPD

Identify all eligible members who, during the measurement year or the year prior to the measurement year, had at least two diagnoses of COPD in any setting. Use Table SPR-A to identify COPD.

Major depression

Identify all eligible members who during the measurement year or the year prior had:

- At least one principal diagnosis of major depression (refer to Table AMM-A) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations), ***or***
- At least two secondary diagnoses of major depression (refer to Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or emergency room visits), ***or***
- At least one secondary diagnosis of major depression (refer to Table AMM-A) associated with any inpatient discharge.

Note: *Lab claims should not be included in the identification of members with depression.*

Hypertension

Identify eligible members with hypertension. A member is considered hypertensive if there are at least two outpatient encounters on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis of hypertension (Table RDI-G). A diagnosis of hypertension (Table RDI-G) must occur in conjunction with codes in Table RDI-H to count.

Table RDI-G: Code to Identify Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

Table RDI-H: Codes to Identify Outpatient Visits Using Claim/Encounter Data

Description	CPT
Office or other outpatient services	99201-99205, 99211-99215, 99241-99245

Chronic kidney disease

Identify eligible members who had at least two face-to-face encounters with different dates of service in an ambulatory or non-acute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of chronic kidney disease. Members are identified as having chronic kidney disease using codes listed in RDI-I in conjunction with codes from RDI-E to identify setting of care.

Table RDI-I: Code to Identify Chronic Kidney Disease

Description	ICD-9-CM Diagnosis
Chronic kidney disease	585.1-585.4, 585.9

Reporting categories

There are four reporting categories for this measure, listed in order of priority.

1. Type 1 Diabetes, With Comorbidity
2. Type 1 Diabetes, Without Comorbidity
3. Type 2 Diabetes, With Comorbidity
4. Type 2 Diabetes, Without Comorbidity

Assign each member to only one *reporting category*. Members are categorized into the first category listed above for which they are identified. For example, if a member has diabetes type 1 without comorbidity (2) and diabetes type 2 without comorbidity (4), report the member in the *Type 1 Diabetes, Without Comorbidity* category only.

Standard Price Calculations

The measure reports total standard costs, which are assigned by matching codes for services rendered to the eligible population during the measurement year to codes listed in NCQA's Standard Price Tables (tables will be posted on NCQA's Web site at www.ncqa.org by December 1, 2006).

The health plan should sum and report standard prices for the services rendered to members in the eligible population during the measurement year by *reporting category*.

Applying standard price

Standard Price Tables (SPT) categorize services into one of the following.

- Inpatient Facility
- Evaluation and Management (E&M)
- Procedures and Surgery (inpatient and outpatient)
- Pharmacy

Count all services listed by code in the Standard Price Tables (SPT) rendered to members in the eligible population during the measurement year. Using the codes listed in the appropriate SPT table categorize these services into one of the service categories listed above. Count each distinct service rendered to the eligible member. To assign standard price to rendered services, link the services to the NCQA Total Standard Price table, which list the assigned standard price.

Sum the total standard cost for each eligible member. Within each service category listed in Table RDI-J if a member's total standard cost for the service category exceeds the service category "cap" amount, then truncate the member's total standard price as listed in the table. For example, if an eligible member's total Inpatient Facility standard cost was $97,000 during the measurement year, cap the member's total inpatient standard cost at $75,000.

Table RDI-J: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
E&M	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: *Do not exclude members who exceed the capped amount.*

Sum and report the total standard cost for the eligible population in each service category by member cohort in Tables RDI-1/2/3.

See the *Calculating Standard Price* instructions in the Cost of Care Guidelines for steps to categorize service data rendered for each service category and linking service data to NCQA SPT tables.

Selected Frequency Service Calculations

Total Frequency of Service

Service frequency counts are reported for services relevant to the condition. MCOs capture each eligible member's services rendered during the measurement year for the following service categories: inpatient facility discharges, ED visits, and observation room stays. These categories and codes are similar to those in the *Inpatient Utilization—General Hospital/Acute Care, Inpatient Utilization-Nonacute Care,* and *Ambulatory Care* Use of Service measures. Refer to the *Calculating Standard Services Frequency* instructions in the Cost of Care Guidelines.

Sum and report all services in each service category by member cohort in Tables RDI-1/2/3.

Inpatient Facility Discharges

This category measures the number of acute and non-acute inpatient facility discharges. Count each discharge once. Include data from any institution that provides long-term/specialty nonacute care.

Use Table RDI-K to report total discharges for each reporting category by member cohort (age and gender).

Table RDI-K: Codes to Identify Total Inpatient Discharges (Acute and Nonacute)

ICD-9-CM Diagnosis	*WITH*	UB-92 Type of Bill
All principal diagnosis codes		Type of Bill codes: 11X, 12X, 41X, 42X, 84X

OR

DRG
1-432, 433, 439-455, 461, 463-471, 473, 475-540, 541-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code.

OR

Table RDI-K: Codes to Identify Total Inpatient Discharges (Acute and Nonacute) (continued)

Description	UB-92 Type of Bill	UB-92 Revenue	DRG
Hospice	81X, 82X	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	
SNF	21X, 22X	019X	
Hospital transitional care, swing bed or rehabilitation	18X		
Rehabilitation		0118, 0128, 0138, 0148, 0158	462
Respite		0655	

OR

Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)

ED Visits

This category measures use of ED services.

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. Do not count visits to urgent care centers.

Use the codes in Table AMB-B to identify ED visits. Services for members admitted to the hospital from an ED visit should be included in the inpatient category only.

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Trends in utilization of observation rooms are an important aspect of total utilization data and total cost.

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. Use the codes in Table AMB-D to identify observation room visits. Services for members admitted to the hospital from an observation room stay should be included in the inpatient category only.

Note: *For members with both observation room and ED services on the same day, report each service that meets the measure criteria in the appropriate category. Report every instance of the code/service.*

Exclude from Observation Room Stays

- Claims with ED Revenue codes (Form Locator 42) of 45X and report them under *Emergency Department Visits.* ED visits that result in an observation room stay should be reported under *Emergency Department Visits.*
- Claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321, 323).
- UB-92 Revenue codes 0760 and 0769.

Table RDI-1/2/3: Relative Resource Use for People With Diabetes—Commercial, Medicaid, Medicare (Report Separately)

Eligible Population	
Type 1, With Comorbidity _____	Type 2, With Comorbidity _____
Type 1, Without Comorbidity _____	Type 2, Without Comorbidity _____

Medical Benefit Member Months

Member Months (Diabetes Type 1, With Comorbidity)				Member Months (Diabetes Type 1, Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Member Months (Diabetes Type 2, With Comorbidity)				Member Months (Diabetes Type 2, Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Pharmacy Benefit Member Months

Member Months (Diabetes Type 1, With Comorbidity)				Member Months (Diabetes Type 1, Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Member Months (Diabetes Type 2, With Comorbidity)				Member Months (Diabetes Type 2, Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Total Standard Price, by Service Category and Age and Gender
***(Reported by Diabetes Type 1, With Comorbidity; Diabetes Type 2, With Comorbidity; Diabetes Type 1, Without Comorbidity; and Diabetes Type 2, W*ithout Comorbidity)**

18-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-54	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
55-64	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
65-75	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

Service Frequency for Selected Services, by Specific Service and Age and Gender (Reported by Diabetes Type 1, With Comorbidity; Diabetes Type 2, With Comorbidity; Diabetes Type 1, Without Comorbidity; and Diabetes Type 2, Without Comorbidity)

18-44	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
45-54	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
55-64	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
65-75	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Unknown	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Total	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____

Relative Resource Use for People With Asthma (RAS)

SUMMARY OF CHANGES TO HEDIS 2007

- First-year measure.

Description

This measure reports the relative resource use, during the measurement year, for members with asthma. Health plans calculate and report the eligible populations' total standard cost (based on a NCQA provided standard price tables) and utilization by member cohort as instructed in the specification. Upon receiving and based on all health plan data NCQA will calculate *expected* (or average) total standard cost and utilization results (regional and national), after which health plans will receive their observed-to-expected ratio (or relative resource use ratio) for the clinical condition and each service category. When evaluated with the HEDIS *Use of Appropriate Medications for People with Asthma (ASM)* measure, the relative resource use ratios provide a better understanding of the efficiency or value of services rendered by the MCO.

Refer to the Cost of Care Guidelines for definitions, methods to apply standard price to services and calculation processes.

Eligible Population

Note: *The eligible population is the same as the ASM measure with additional exclusions; it is further stratified into reporting categories in the Categorization of the Eligible Population section.*

Product lines Commercial, Medicaid (report each product line separately).

Ages 5–56 years by December 31 of the measurement year.

Continuous enrollment The measurement year and the year prior to the measurement year.

Allowable gap No more than 1 gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the member may not have more than a 1-month gap in coverage during each year of continuous enrollment year.

Anchor date December 31 of the measurement year.

Benefits Medical. Pharmacy during the measurement year.

Event/diagnosis Follow the steps below to identify the eligible population for the measure.

Step 1 Identify members as having persistent asthma who met at least one of the four criteria below, during *both* the measurement year and the year prior to the measurement year (criteria need not be the same across years).

- At least one ED visit (Tables ASM-A and ASM-B) with asthma as the principal diagnosis
- At least one acute inpatient discharge (Tables ASM-A and ASM-B), with asthma as the principal diagnosis
- At least four outpatient asthma visits (Tables ASM-A and ASM- B), with asthma as a listed diagnosis and at least two asthma medication dispensing events (Tables ASM-C)

- At least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions) (Table ASM-C)

Step 2 For a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the member must:

- Meet any of the other three criteria in step 1 in the same year as the leukotriene modifier, ***or***
- Have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Exclusions *(optional)*

Note: *MCOs that apply the optional exclusions for the Use of Appropriate Medications for People With Asthma measure* must *apply the optional exclusion for the Relative Resource Use for People With Asthma measure.*

Exclude from the eligible population all members diagnosed with emphysema or COPD any time on or prior to December 31 of the measurement year, as identified by the codes in Table ASM-C.

Exclusions *(required)*

- Exclude from the eligible population members identified as having one or more of the following dominant conditions during the measurement year
  - Active cancer
  - Organ transplant
  - ESRD
  - HIV/AIDS
- *For active cancer and ESRD,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a diagnosis code and with a procedure or revenue code listed in table RDI-A and RDI-B.
- *For organ transplant,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a procedure or revenue code listed in table RDI-C.
- *For HIV/AIDS,* exclude members who had at least two face-to-face encounters with different dates of service in an ambulatory or nonacute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year with a diagnosis code listed in Table RDI-D. Use the codes in Table RDI-E to identify the setting of care.

Categorization of Eligible Population

Major clinical condition	Asthma.
Clinical category	None.
Comorbid categorization	Members in the eligible population with evidence of cardiovascular conditions, diabetes, depression, COPD or hypertension are identified to be “with comorbidity” for the measure. The MCO must use all methods to identify comorbid status; however, once a member meets the criteria for one of the comorbid conditions, the MCO does not need to verify if the member has any of the remaining comorbid conditions listed. Follow the instructions for each comorbid condition.

Cardiovascular conditions

Identify members for cardiovascular condition comorbidity in one of two ways: *event* or *diagnosis* occurring during the measurement year or the year prior to the measurement year. The MCO must use both criteria to identify comorbidity status.

- *Event.* Discharged alive for AMI, CABG or PTCA. Use the codes listed in Table CMC-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).
- *Diagnosis*. At least one diagnosis of IVD in any setting (Table CMC-B).

Diabetes

Two methods are provided to identify diabetic members.

1. Pharmacy data
2. Claim/encounter data

The MCO must use both methods to identify a member as diabetic; however, a member only needs to be identified in one method to be included in the comorbid category. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Refer to Table CDC-A.

Claim/encounter data. Members who had two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. The MCO may count services that occur over both years.

Use the codes in Tables CDC-B and CDC-C to identify ambulatory or nonacute inpatient and acute inpatient or ED encounters.

Major depression

Identify all eligible members who, during the measurement year or the year prior, had:

- At least one principal diagnosis of major depression (refer to Table AMM-A) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations), **or**
- At least two secondary diagnoses of major depression (refer to Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or emergency room visits), ***or***
- At least one secondary diagnosis of major depression (refer to Table AMM-A) associated with any inpatient discharge.

Note: *Lab claims should not be included in the identification of members with depression.*

COPD

Identify all eligible members who during the measurement year or the year prior to the measurement year had at least two diagnosis of COPD in any setting. Use Table SPR-A to identify COPD.

Hypertension

Identify eligible members with hypertension. A member is considered hypertensive if there are at least two outpatient encounters (Table RDI-H) on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis of hypertension (RDI-G). Codes in Table RDI-G must occur in conjunction with codes in Table RDI-H.

Reporting categories

There are two reporting categories for this measure, listed in order of priority.

1. Asthma, With Comorbidity
2. Asthma, Without Comorbidity

Assign each member to only one *reporting category*. Members are categorized into the first category listed for which they are identified.

Standard Price Calculations

The measure reports total standard costs, which are assigned by matching codes for services rendered to the eligible population during the measurement year to codes listed in NCQA's Standard Price Tables (tables will be posted on NCQA's Web site at www.ncqa.org by December 1, 2006).

The health plan should sum and report standard prices for the services rendered to members in the eligible population during the measurement year by *reporting category*.

Total Standard Price (TSP)

Standard Price Tables (SPT) categorize services into one of the following.

- Inpatient Facility
- Evaluation and Management (E&M)
- Procedures and Surgery (inpatient and outpatient)
- Pharmacy

Capture all services rendered to members in the eligible population during the measurement year. Using the codes listed in the appropriate SPT table categorize these services into one of the service categories listed above. Count each distinct service rendered to the eligible member. To assign standard price to rendered services, link the services to the NCQA Total Standard Price table, which list the assigned standard price.

Within each service category listed in Table RAS-A if a member's price exceeds the service category "cap" amount, then truncate the member's total standard price as listed in the table. For example, if an eligible member total inpatient standard price was $97,000 during the measurement year cap the member's total inpatient standard price at $75,000.

Table RAS-A: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
E&M	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: *Do not exclude members who exceed the capped amount.*

Sum and report the total standard price for the eligible population in each service category by member cohort in Table RAS-1/2.

See the *Calculating Standard Price* instructions in the Cost of Care Guidelines for calculating inpatient facility category and linking service data to NCQA TSP tables.

Selected Frequency Service Calculations

Total Service Frequency (TSF)

Service frequency counts are reported for services relevant to the condition. MCOs capture each eligible member's services rendered during the measurement year for the following service categories: inpatient facility discharges, ED visits and observation room stays. These categories and codes are similar to those in the *Inpatient Utilization—General Hospital/Acute Care, Inpatient Utilization-Nonacute Care,* and *Ambulatory Care* Use of Service measures.

Refer to the Calculating Standard Services Frequency instructions in the Cost of Care *Guidelines*.

Sum and report all services in each service category by member cohort in Table RAS-1/2.

Inpatient Facility Discharges

This category measures the number of acute and non-acute inpatient facility discharges. Count each discharge once. Include data from any institution that provides long-term/specialty nonacute care.

Use Table RAS-B to report total discharges for each reporting category by member cohort (age and gender).

Table RAS-B: Codes to Identify Total Inpatient Discharges (Acute and Nonacute)

	WITH	UB-92 Type of Bill
All principal diagnosis codes		11X, 12X, 41X, 42X, 84X

OR

DRG
1-432, 433, 439-455, 461, 463-471, 473, 475-540, 541-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code.

OR

Description	UB-92 Type of Bill	UB-92 Revenue	DRG
Hospice	81X, 82X	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	
SNF	21X, 22X	019X	
Hospital transitional care, swing bed or rehabilitation	18X		
Rehabilitation		0118, 0128, 0138, 0148, 0158	462
Respite		0655	

OR

Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)

ED Visits

This category measures use of ED services.

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. Do not count visits to urgent care centers.

Use the codes in Table AMB-B to identify ED visits. Services for members admitted to the hospital from an ED Visit should be included in the inpatient category only.

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Trends in utilization of observation rooms are an important aspect of total utilization data and total cost.

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. Use the codes in Table AMB-D to identify observation room visits. Services for members admitted to the hospital from an observation room stay should be included in the inpatient category only.

Note: *For members with multiple observation room or ED services on the same day, report each service that meets the measure criteria in the appropriate category. Report every instance of the code/service.*

Exclude from Observation Room Stays

- Claims with ED Revenue codes (Form Locator 42) of 45X and report them under *Emergency Department Visits.* ED visits that result in an observation room stay should be reported under *Emergency Department Visits.*
- Claims with urgent care Revenue code (Form Locator 42) 456.
- Claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321, 323).
- UB-92 Revenue codes 0760 and 0769.

Table RAS-1/2: Relative Resource Use for People with Asthma—Commercial, Medicaid (Report Separately)

Eligible Population	
Eligible Population With Comorbidity	_____
Eligible Population Without Comorbidity	_____

Medical Benefit Member Months

	Member Months (Asthma With Comorbidity)			Member Months (Asthma Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
5-17	_____	_____	_____	_____	_____	_____
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-56	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Pharmacy Benefit Member Months

Member Months (Asthma With Comorbidity)				Member Months (Asthma Without Comorbidity)		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
5-17	_____	_____	_____	_____	_____	_____
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-56	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

*Total Standard Price, by Service Category and Age and Gender (Reported by Asthma W*ith Comorbidity)

5-17	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
18-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-54	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
55-56	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

***Service Frequency for Selected Services, by Specific Service, Age and Gender (Reported by Asthma Without* Comorbidityy)**

5-17	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
18-44	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
45-54	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
55-56	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Unknown	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Total	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____

Relative Resource Use for People With Acute Low Back Pain (RLB)

SUMMARY OF CHANGES TO HEDIS 2007

- First-year measure.

Description

This measure reports the relative resource use during an acute low back pain Episode Treatment Period, for members identified with a new diagnosis of low back pain. Health plans calculate and report the eligible populations' total standard cost of services rendered during the Episode Treatment Period (based on a NCQA provided standard price table) and utilization by member cohort as instructed in the specification. Upon receiving and based on all health plan data NCQA will calculate *expected* (or average) total standard cost and utilization results (regional and national), after which health plans will receive their observed-to-expected ratio (or relative resource use ratio) for the clinical condition and each service category. When evaluated with the HEDIS *Use of Imaging Studies for Low Back Pain (LBP)* measure, the relative resource use ratios provide a better understanding of the efficiency or value of services rendered by the MCO. This measure is related to the acute low back pain condition and only includes services for low back pain. This measure does not include cohorts by comorbid condition.

Refer to the Cost of Care Guidelines for definitions, methods to apply standard price to services and calculation processes.

Definitions

Episode Start Date	The earliest encounter during the measurement year with a primary low back pain diagnosis (Table LBP-A).
New Episode	The first claim/encounter during the measurement year that meets the qualifying diagnosis criteria (Table LBP-A) and a 180-day Negative Diagnosis History.
Negative Diagnosis History	A period of 180 days (6 months) prior to the Episode Start Date during which time the member had no claims/encounters with a diagnosis of low back pain (Table LBP-A).
Episode Treatment Period	The period between the Episode Start Date and the 28 days following the Episode Start Date.

Eligible Population

Note: *The eligible population is the same as that of the LBP measure with additional exclusions; it is further stratified into reporting categories in the Categorization of the Eligible Population section.*

Product line	Commercial, Medicaid (report each product line separately).
Ages	18–50 years as of December 31 of the measurement year.
Continuous enrollment	180 days prior to the Episode Start Date through 28 days after the Episode Start Date.
Allowable gap	No gaps in enrollment during the continuous enrollment period.
Anchor date	Episode Start Date.
Benefit	Medical.

Event/ diagnosis

Low back pain. The MCO should use claims/encounter data to identify members with a new episode of low back pain (Table LPB-A) and follow the steps below to identify the eligible population for this measure.

Step 1 Identify all members in the specified age range who had an ambulatory encounter with a principal diagnosis of low back pain between January 1 and December 31 of the measurement year. Use Table LBP-A to identify ambulatory encounters. Count the procedure and UB-92 Revenue codes listed in LBP-A only if they appear in conjunction with a back pain diagnosis.

Note: Count CPT and UB-92 Revenue codes *only* if they appear in conjunction with an applicable low back pain diagnosis.

Step 2 Determine the Episode Start Date for each member by identifying the date of the member's earliest encounter (identified in step 1) during the measurement year (i.e., ambulatory encounter with qualifying low back pain diagnosis—Table LBP-A).

Step 3 Determine if the Episode Start Date is a New Episode. Members with a New Episode of low back pain must have a Negative Diagnosis History. Members with a low back pain diagnosis within the previous 180 days (6 months) of the Episode Start Date should be dropped from the denominator.

Step 4 Exclude members with a diagnosis for which an imaging study in the presence of low back pain is clinically indicated. The MCO should use the codes from Table LBP-B to exclude members with the following diagnoses from the denominator.

Recent trauma, intravenous drug abuse, neurological impairment: The MCO should exclude members with any applicable diagnoses in the 12 months prior to the Episode Start Date through the end of the continuous enrollment period.

Step 5 Calculate continuous enrollment. The member must be continuously enrolled without any gaps for 180 days prior to the Episode Start Date through 28 days after the Episode Start Date to determine if an imaging study was ordered and conducted.

Exclusions *(required)*

- Exclude from the eligible population members identified as having one or more of the following dominant conditions during the measurement year.
  - Active cancer
  - Organ transplant
  - ESRD
  - HIV/AIDS
- *For active cancer and ESRD,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a diagnosis code and with a procedure or revenue code listed in Tables RDI-A and RDI-B.
- *For organ transplant,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a procedure or revenue code listed in table RDI-C.
- *For HIV/AIDS,* exclude members who had at least two face-to-face encounters with different dates of service in an ambulatory or nonacute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year with a diagnosis code listed in Table RDI-D. Use the codes in Table RDI-E to identify the setting of care.

Categorization of Eligible Population

Major clinical condition Acute low back pain.

Clinical category None.

Comorbid categorization NA.

Reporting categories Acute low back pain.

Standard Price Calculations

The measure reports standard prices, which are assigned by matching codes for services rendered to the eligible population during the Episode Treatment Period with a diagnosis of low back pain, primary or secondary (refer to Table LBP-A for low back pain diagnosis). The codes listed in NCQA's Standard Price Tables (tables will be posted on NCQA's Web site at www.ncqa.org by December 1, 2006).

The health plan should sum and report standard prices for the services rendered to members in the eligible population during the Episode Treatment Period by *reporting category*.

Total Standard Price (TSP)

Standard Price Tables categorize services into one of the following.

- Inpatient Facility
- Evaluation and Management (E&M)
- Procedures and Surgery (inpatient and outpatient)
- Pharmacy

Capture all services rendered to members in the eligible population during the Episode Treatment Period. Using the appropriate SPT table categorize these services into one of the service categories listed above. Count each distinct service rendered to the eligible member. To assign standard price to rendered services, link the services to the NCQA Total Standard Price table, which list the assigned standard price.

Within each service category listed in Table RLB-A if a member's price exceeds the service category "cap" amount, then truncate the member's total standard price as listed in the table. For example, if an eligible member total inpatient standard price was $97,000 during the Episode Treatment Period cap the member's total inpatient standard price at $75,000.

Table RLB-A: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
Evaluation and Management (E&M)	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: *Do not exclude members who exceed the capped amount.*

Sum and report the total standard price for the eligible population in each service category by member cohort in Table RLB-1/2.

See the *Calculating Standard Price* instructions in the Cost of Care Guidelines on steps to calculate inpatient facility category and linking service data to NCQA TSP tables.

Selected Frequency Services Calculations

Total Service Frequency (TSF)

Service frequency counts are reported for services with a diagnosis of low back pain, primary or secondary (refer to Table LBP-A for low back pain diagnosis) during the Episode Treatment Period. MCOs capture each eligible member's services rendered during the Episode Treatment Period for the following service categories: inpatient facility discharges, ED visits, and observation room stays. These categories and codes are similar to or the same as those in the *Inpatient Utilization—General Hospital/Acute Care* and *Ambulatory Care* Use of Service measures.

Refer to the *Calculating Standard Services Frequency* instructions in the Cost of Care Guidelines. Sum and report all services in each service category by member cohort in Table RLB-1/2.

Inpatient Facility Discharges

This category measures the number of acute and non-acute inpatient facility discharges. Count each discharge once. Include data from any institution that provides long-term/specialty nonacute care.

Use Table RLB-B to report total discharges for each reporting category by member cohort (age and gender).

Table RLB-B: Codes to Identify Total Inpatient Discharges (Acute and Nonacute)

ICD-9-CM Diagnosis	*WITH*	UB-92 Type of Bill
All principal diagnosis codes		11X, 12X, 41X, 42X, 84X

OR

DRG
1-432, 433, 439-455, 461, 463-471, 473, 475-540, 541-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code.

OR

Description	UB-92 Type of Bill	UB-92 Revenue	DRG
Hospice	81X, 82X	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	
SNF	21X, 22X	019X	
Hospital transitional care, swing bed or rehabilitation	18X		
Rehabilitation		0118, 0128, 0138, 0148, 0158	462
Respite		0655	

OR

Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)

ED Visits

This category measures use of ED services.

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. Do not count visits to urgent care centers.

Use the codes in Table AMB-B to identify ED visits. Services for members admitted to the hospital from an ED Visit should be included in the inpatient category only.

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Trends in utilization of observation rooms are an important aspect of total utilization data.

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. Use the codes in Table AMB-D to identify observation room visits.

Do not count patients admitted to the hospital from the observation unit (whose observation unit stay would be billed on an inpatient bill). Services for members admitted to the hospital from an observation room stay should be included in the inpatient category only.

Exclude from Observation Room Stays

- Claims with ED Revenue codes (Form Locator 42) of 45X and report them under *Emergency Department Visits.* ED visits that result in an observation room stay should be reported under *Emergency Department Visits.*
- Claims with urgent care Revenue code (Form Locator 42) 456.
- Claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321, 323).
- UB-92 Revenue codes 0760 and 0769.

Note: *For members with multiple observation room or ED services on the same day, report each service that meets the measure criteria in the appropriate category. Report every instance of the code/service.*

MRI

Count once, each magnetic resonance imaging (MRI) on different dates of service during the Episode Treatment Period (Table RLB-C). Count CPT and UB-92 Revenue codes only if they appear in conjunction with an applicable low back pain diagnosis.

Table RLB-C: Codes to Identify Imaging Studies for Low Back Pain

Description	CPT*	UB-92 Revenue*
Magnetic resonance imaging	72141, 72142, 72146, 72147, 72148, 72149, 72156, 72158	0610, 0612, 0614, 0619

*Imaging CPT and UB-92 codes should only be counted if they appear in conjunction with applicable low back pain diagnosis.

Table RLB-1/2: Relative Resource Use for People with Acute Low Back Pain—Commercial, Medicaid (Report Separately)

Eligible Population

Eligible population _____

Medical Benefit Member Months

Member Months			
Age	**Male**	**Female**	**Total**
18-44	_____	_____	_____
45-50	_____	_____	_____
Unknown	_____	_____	_____
Total:	_____	_____	_____

Pharmacy Benefit Member Months

Member Months			
Age	**Male**	**Female**	**Total**
18-44	_____	_____	_____
45-50	_____	_____	_____
Unknown	_____	_____	_____
Total:	_____	_____	_____

Total Standard Price, by Service Category and Age and Gender

18-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-50	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

Service Frequency for Selected Services, by Specific Service and Age and Gender

18-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-50	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

Relative Resource Use for People With Cardiovascular Conditions (RCA)

SUMMARY OF CHANGES TO HEDIS 2007

- For informational purposes only. This measure will not be collected for HEDIS 2007; it will be a first-year measures in HEDIS 2008.
- In HEDIS 2008, this measure will align with any changes made to the *Cholesterol Management for Patients with Cardiovascular Conditions (CMC)* measure.

Description

This measure reports the relative resource use during the measurement year, for members with cardiovascular conditions. Health plans calculate and report the eligible populations' total standard cost (based on a NCQA provided standard price table) and utilization by member cohort as instructed in the specification. Upon receiving and based on all health plan data NCQA will calculate *expected* (or average) total standard cost and utilization results (regional and national), after which health plans will receive their observed-to-expected ratio (or relative resource use ratio) for the clinical condition and each service category. When evaluated with the HEDIS *Cholesterol Management for Patients with Cardiovascular Conditions (CMC)* measure, the relative resource use ratios provide a better understanding of the efficiency or value of services rendered by the MCO.

Refer to the Cost of Care Guidelines for definitions, methods to apply standard price to services and calculation processes.

Eligible Population

Note: *The eligible population starts with the CMC measure with additional exclusions; it is further stratified into clinical groups and reporting categories in the Categorization of the Eligible Population section.*

Product lines	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 years as of December 31 of the measurement year.
Continuous enrollment	The measurement year and the year prior to the measurement year
Allowable gap	No more than one gap in enrollment of up to 45 days during each year of continuous enrollment. To determine continuous enrollment for a Medicaid beneficiary 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	Enrolled as of December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Members are identified for the denominator in one of two ways: 1. Event 2. Diagnosis. The MCO must use both criteria to identify the eligible population.

Event. Discharged alive for AMI, CABG or PTCA on or between January 1 and November 1 of the year prior to the measurement year. Use the codes listed in Table CMC-A to identify AMI, CABG and PTCA. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).

Diagnosis. At least one outpatient/nonacute inpatient or acute inpatient/ED visit with any diagnosis of IVD (Table CMC-B).

Exclusions *(required)*

- Exclude from the eligible population members during the measurement year identified as having one or more of the following dominant conditions.
  - Active cancer
  - Organ transplants
  - ESRD
  - HIV/AIDS
- *For active cancer and ESRD,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a diagnosis code and with a procedure or revenue code listed in table RDI-A and RDI-B.
- *For organ transplant,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a procedure or revenue code listed in table RDI-C.
- *For HIV/AIDS,* exclude members who had at least two face-to-face encounters with different dates of service in an ambulatory or nonacute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year with a diagnosis code listed in Table RDI-D. Use the codes in Table RDI-E to identify the setting of care.

Categorization of Eligible Population

Major clinical condition Cardiovascular condition (disease).

Clinical category For cardiovascular conditions, clinical categories are:

- Chronic heart failure (CHF)
- Acute myocardial infarction (AMI)
- Coronary artery disease (CAD)
- Angina.

To stratify members into these categories, identify members as having cardiovascular conditions who meet the criteria listed in Table RCA-A during the measurement year and follow steps 1-3.

Step 1 Eligible members who had at least two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year, with a diagnosis of one of the corresponding cardiac conditions listed in Table RCA-A. Refer to Table RDI-E for identification of setting of care.

Step 2 A member can only be included in one clinical category. A member who meets the criteria for more than one is included in the more severe clinical category condition. Clinical categories are listed in order from "highest" to "lowest" level of severity; for example, a member identified with both CAD and CHF is included in the CHF clinical category only.

Step 3 Exclude members who do not meet the criteria of any clinical category.

Table RCA-A: Codes to Identify Cardiovascular Conditions Using Claim/Encounter Data

Description	ICD-9-CM Diagnosis	CPT
Cardiovascular disease	• CAD: 411, 414 -414.09 • Angina: 413 • AMI: 410 • CHF: 428	*CAD:* 92980-92982, 92984, 92995-92998, 33510-33519, 33521-33523, 33533-33536, 33542, 33545, 35600, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35641, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 33572, 35500-35571

Comorbid categorization

Members in the eligible population with evidence of asthma, COPD, depression, hypertension, or chronic kidney disease are identified to be "with comorbidity" for the measure. The MCO must use all methods to identify comorbid status; however, once a member meets the criteria for one of the comorbid conditions the MCO does not need to verify if the member has any of the remaining comorbid conditions listed. Follow the instructions for each comorbid condition.

Asthma

Step 1 Identify members as having persistent asthma who met at least one of the four criteria below, during the measurement year or the year prior to the measurement year.

- At least one ED visit (Tables ASM-A and ASM-B), with asthma (ICD-9-Diagnosis 493) as the principal diagnosis
- At least one acute inpatient discharge (Tables ASM-A and ASM-B), with asthma as the principal diagnosis
- At least four outpatient asthma visits (Tables ASM-A and ASM-B), with asthma as a listed diagnosis and at least two asthma medication dispensing events (Table ASM-C)
- A least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions) (Table ASM-C)

Step 2 For a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the member must:

- Meet any of the other three criteria listed above, ***or***
- Have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e., the measurement year or the year prior to the measurement year).

COPD

Identify all eligible members who during the measurement year or year prior to the measurement year had at least two diagnosis of COPD in any setting. Use Table SPR-A to identify COPD.

Diabetes

Two methods are provided to identify diabetic members:

1. Pharmacy data
2. Claim/encounter data.

The MCO must use both methods to identify a member as diabetic; however, a member only needs to be identified in one method to be included in the comorbid category. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Refer to Table CDC-A.

Claim/encounter data. Members who had two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. The MCO may count services that occur over both years.

Use the codes in Tables CDC-B and CDC-C to identify ambulatory or nonacute inpatient and acute inpatient or ED encounters.

Major depression

Identify all eligible members with a diagnosis of depression who, during the measurement year or year prior had:

- At least one principal diagnosis of major depression (refer to Table AMM-A) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations), ***or***
- At least two secondary diagnoses of major depression (refer to Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or emergency room visits), ***or***
- At least one secondary diagnosis of major depression (refer to Table AMM-A) associated with any inpatient discharge.

Note: *Do not include lab claims in the identification of members with depression.*

Hypertension

Identify eligible members with hypertension. A member is considered hypertensive if there are at least two outpatient encounters (Table RDI-H) on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis of hypertension (Table RDI-G). Codes in Table RDI-G must occur in conjunction with codes in Table RDI-H to count.

Reporting categories

Count members in only one cardiovascular clinical reporting category (listed from most severe to least severe).

- CHF, With Comorbidity
- CHF, Without Comorbidity
- AMI, With Comorbidity
- AMI, Without Comorbidity
- CAD, With Comorbidity
- CAD, Without Comorbidity
- Angina, With Comorbidity
- Angina, Without Comorbidity

Assign each member based on severity; for example, a member identified with both angina, with comorbidity and AMI, with comorbidity is included in the AMI, With Comorbidity clinical category only.

Standard Price Calculations

The measure reports total standard costs, which are assigned by matching codes for services rendered to the eligible population during the measurement year to codes listed in NCQA's Standard Price Tables (tables will be posted on NCQA's Web site at www.ncqa.org by December 1, 2006).

The health plan should sum and report standard prices for the services rendered to members in the eligible population during the measurement year by *reporting category*.

Total Standard Price (TSP)

Standard Price Tables (SPT) categorize services into one of the following.

- Inpatient Facility
- Evaluation and Management (E&M)
- Procedures and Surgery (inpatient and outpatient)
- Pharmacy

Count all services listed by code in the Standard Price Tables (SPT) rendered to members in the eligible population during the measurement year. Using the codes listed in the appropriate SPT table categorize these services into one of the service categories listed above. Count each distinct service rendered to the eligible member. To assign standard price to rendered services, link the services to the NCQA Total Standard Price table, which list the assigned standard price.

Sum the total standard cost for each eligible member. Within each service category listed in Table RCA-B if a member's total standard cost for the service category exceeds the service category "cap" amount, then truncate the member's total standard price as listed in the table. For example, if an eligible member's total Inpatient Facility standard cost was $97,000 during the measurement year, cap the member's total inpatient standard cost at $75,000.

Table RCA-B: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
E&M	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: *Do not exclude members who exceed the capped amount.*

Sum and report the total standard cost for the eligible population in each service category by member cohort in Table RCA-1/2/3.

See the *Calculating Standard Price* instructions in the Cost of Care Guidelines for steps to categorize service data rendered for each service category and linking service data to NCQA SPT tables.

Selected Frequency Services Calculations

Total Service Frequency (TSF)

Service frequency counts are reported for services relevant to the condition. MCOs capture each eligible member's services rendered during the measurement year for the following service categories: inpatient facility discharges, ED visits, and observation room stays. These categories and codes are similar or the same as those in the *Inpatient-Utilization—General Hospital/Acute Care (IPU)* and *Ambulatory Care (AMB)* Use of Service measures.

See the *Calculating Standard Services Frequencies* instructions in the Cost of Care Guidelines.

Sum and report the all services in each service category by member cohort in Table RCA-1/2/3.

RCA-1 Inpatient Facility Discharges

This category measures the number of acute and nonacute inpatient facility discharges. Count each discharge once. Include data from any institution that provides long-term/ specialty nonacute care.

Use Table RCA-C to report total discharges for each reporting category by member cohort (age and gender).

Table RCA-C: Codes to Identify Total Inpatient Discharges (Acute and Nonacute)

ICD-9-CM Diagnosis	*WITH*	UB-92 Type of Bill
All principal diagnosis codes		11X, 12X, 41X, 42X, 84X

OR

DRG
1-432, 433, 439-455, 461, 463-471, 473, 475-540, 541-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code.

OR

Description	UB-92 Type of Bill	UB-92 Revenue	DRG
Hospice	81X, 82X	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	
SNF	21X, 22X	019X	
Hospital transitional care, swing bed or rehabilitation	18X		
Rehabilitation		0118, 0128, 0138, 0148, 0158	462
Respite		0655	

OR

Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)

ED Visits

This category measures use of ED services.

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. Do not count visits to urgent care centers.

Use the codes in Table AMB-B to identify ED visits. Services for members admitted to the hospital from an ED visit should be included in the inpatient category only.

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Trends in utilization of observation rooms are an important aspect of total utilization data.

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. Use the codes in Table AMB-D to identify observation room visits.

Note: *For members with multiple observation room or ED services on the same day, report each service that meets the measure criteria in the appropriate category. Report every instance of the code/service.*

Exclude from Observation Room Stays

- Claims with ED Revenue codes (Form Locator 42) of 45X and report them under *Emergency Department Visits.* ED visits that result in an observation room stay should be reported under *Emergency Department Visits.*
- Claims with urgent care Revenue code (Form Locator 42) 456.
- Claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321, 323).
- UB-92 Revenue codes 0760 and 0769.

Table RCA-1/2/3: Relative Resource Use for People with Cardiovascular Conditions—Commercial, Medicaid, Medicare (Report Separately)

Eligible Population

Eligible Population CHF, With Comorbidity	_____	Eligible Population CAD, With Comorbidity	_____
Eligible Population CHF, Without Comorbidity	_____	Eligible Population CAD, Without Comorbidity	_____
Eligible Population AMI, With Comorbidity	_____	Eligible Population Angina, With Comorbidity	_____
Eligible Population AMI, Without Comorbidity	_____	Eligible Population Angina, Without Comorbidity	_____

Medical Benefit Member Months

Member Months (CHF With Comorbidity)				Member Months (CHF Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Member Months (AMI With Comorbidity)				Member Months (AMI Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Member Months (CAD With Comorbidity)				Member Months (CAD Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Member Months (Angina With Comorbidity)				Member Months (Angina Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44	_____	_____	_____	_____	_____	_____
45-54	_____	_____	_____	_____	_____	_____
55-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Pharmacy Benefit Member Months

Member Months (CHF With Comorbidity)				Member Months (CHF Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44						
45-54						
55-64						
65-75						
Unknown						
Total:						

Member Months (AMI With Comorbidity)				Member Months (AMI Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44						
45-54						
55-64						
65-75						
Unknown						
Total:						

Member Months (CAD With Comorbidity)				Member Months (CAD Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44						
45-54						
55-64						
65-75						
Unknown						
Total:						

Member Months (Angina With Comorbidity)				Member Months (Angina Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
18-44						
45-54						
55-64						
65-75						
Unknown						
Total:						

Total Standard Price, by Service Category and Age and Gender
(Report Separately by CHF With Comorbidity, AMI With Comorbidity, CAD With Comorbidity, Angina With Comorbidity, CHF Without Comorbidity, AMI Without Comorbidity, CAD Without Comorbidity, Angina Without Comorbidity)

18-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-54	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
55-64	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
65-75	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

***Service Frequency for Selected Services, by Specific Service and Age and Gender (Report Separately by CHF With Comorbidity, AMI With Comorbidity, CAD With Comorbidity, Angina With Comorbidity, CHF Without Comorbidity, AMI Without Comorbidity, CAD Without Comorbidity,* Angina Without Comorbidity)**

18-44	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
45-54	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
55-64	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
65-75	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Unknown	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Total	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____

Relative Resource Use for People With Uncomplicated Hypertension (RHY)

SUMMARY OF CHANGES TO HEDIS 2007

- For informational purposes only. This measure will not be collected for HEDIS 2007; it will be a first-year measure in HEDIS 2008.

Description

This measure reports the relative resource use, during the measurement year, for members with uncomplicated hypertension. Health plans calculate and report the eligible populations' total standard cost (based on a NCQA provided standard price table) and utilization by member cohort as instructed in the specification. Upon receiving and based on all health plan data NCQA will calculate *expected* (or average) total standard cost and utilization results (regional and national), after which health plans will receive their observed-to-expected ratio (or relative resource use ratio) for the clinical condition and each service category. When evaluated with the HEDIS *Controlling High Blood Pressure (CBP)* measure, the relative resource use ratios provide a better understanding of the efficiency or value of services rendered by the MCO.

See the Cost of Care Guidelines for definitions, methods to apply standard price to services and calculation processes.

Eligible Population

Note: *The eligible population is similar to the CBP measure but uses an administrative-only specification and applies additional exclusions. The measure's eligible population is further stratified in Eligible Population Categorization.*

Product line	Commercial, Medicaid, Medicare (report each product line separately).
Ages	18–75 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 measurement year. To determine continuous enrollment for a Medicaid beneficiary 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	Identify members as having hypertension who met the criteria listed during the measurement year. Identify members as having *uncomplicated* hypertension who do not have one of the listed excluded conditions (refer to *Exclusions* for diagnosis codes). Claim/encounter data. Members who had at least two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting, or in an acute inpatient or emergency room setting during the measurement year, with a diagnosis of hypertension. Use the codes in Table RHY-A to identify members with ED encounters.

Exclusions *(required)*

- Exclude from the eligible population members identified as having one or more of the following dominant conditions during the measurement year.
  - Active cancer
  - Organ transplant
  - ESRD
  - HIV/AIDS
- *For active cancer and ESRD,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a diagnosis code and with a procedure or revenue code listed in Tables RDI-A and RDI-B.
- *For organ transplant,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a procedure or revenue code listed in table RDI-C.
- *For HIV/AIDS,* exclude members who had at least two face-to-face encounters with different dates of service in an ambulatory or nonacute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year with a diagnosis code listed in Table RDI-D. Use the codes in Table RDI-E to identify the setting of care.

Exclusions (optional)

Asthma

Step 1 Identify members as having persistent asthma who met at least one of the four criteria below, during the measurement year or the year prior to the measurement year.

- At least one ED visit (Tables ASM-A and ASM-B), with asthma (ICD-9 code 493) as the principal diagnosis
- At least one acute inpatient discharge (Tables ASM-A and ASM-B), with asthma as the principal diagnosis
- At least four outpatient asthma visits (Tables ASM-A and ASM-B), with asthma as a listed diagnosis and at least two asthma medication dispensing events (Table ASM-C)
- A least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions) (Table ASM-C)

Step 2 For a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the member must:

- Meet any of the other three criteria listed above, ***or***
- Have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Cardiovascular conditions Identify members for cardiovascular condition comorbidity in one of two ways:

1. Event, ***or***

2. Diagnosis occurring during the measurement year or the year prior to the measurement year.

The MCO must use both criteria to identify comorbidity status.

Event. Discharged alive for AMI, CABG or PTCA. Use the codes listed in Table CMC-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).

Diagnosis. At least one outpatient/nonacute inpatient or acute inpatient/ED visit with any diagnosis of IVD (Table CMC-B).

COPD

Identify all eligible members who during the measurement year or year prior to the measurement year had at least two diagnosis of COPD in any setting. Use Table SPR-A to identify COPD.

Diabetes

Identify diabetic members in two ways:

1. Pharmacy data
2. Claim/encounter data.

The MCO must use both methods to identify the diabetics; however, a member only needs to be identified in one method to be included in the comorbid category. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Refer to Table CDC-A.

Claim/encounter data. Members who had two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. The MCO may count services that occur over both years.

Use the codes in Tables CDC-B and CDC-C to identify ambulatory or nonacute inpatient and acute inpatient or ED encounters.

Major depression

Identify all eligible members with a diagnosis of depression who, during the measurement year or year prior to the measurement year, had:

- At least one principal diagnosis of major depression (refer to Table AMM-A) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations), ***or***
- At least two secondary diagnoses of major depression (refer to Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or emergency room visits), ***or***
- At least one secondary diagnosis of major depression (refer to Table AMM-A) associated with any inpatient discharge.

Note: *Do not include lab claims in the identification of members with depression.*

Categorization of Eligible Population

Major clinical category Hypertension.

Clinical category None.

Comorbid conditions None.

Reporting categories Hypertension, uncomplicated.

Table RHY-A: Code to Identify Uncomplicated Hypertension

Description	ICD-9-CM Diagnosis
Hypertension	401

Standard Price Calculations

The measure reports standard prices, which are assigned by matching codes for services rendered to the eligible population during the measurement year to codes listed in NCQA's Standard Price Tables (tables will be posted on NCQA's Web site at www.ncqa.org by December 1, 2006).

The health plan should sum and report standard prices for the services rendered to members in the eligible population during the measurement year by *reporting category*.

Total Standard Price (TSP)

Standard Price Tables categorize services into one of the following.

- Inpatient Facility
- Evaluation and Management (E&M)
- Procedures and Surgery (inpatient and outpatient)
- Pharmacy

Capture all services rendered to members in the eligible population during the measurement year. Using the appropriate SPT table categorize these services into one of the service categories listed above. Count each distinct service rendered to the eligible member. To assign standard price to rendered services, link the services to the NCQA Total Standard Price table, which list the assigned standard price.

Within each service category listed in Table RHY-B if a member's price exceeds the service category "cap" amount, then truncate the member's total standard price as listed in the table. For example, if an eligible member total inpatient standard price was $97,000 during the measurement year, cap the member's total inpatient standard price at $75,000.

Table RHY-B: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
Evaluation and Management (E&M)	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: *Do not exclude members who exceed the capped amount.*

Sum and report the total standard price for the eligible population in each service category by member cohort in Table RHY-1/2/3.

See the *Calculating Standard Price* instructions in the Cost of Care Guidelines on steps to calculate inpatient facility category and linking service data to NCQA TSP tables.

Selected Frequency Service Calculations

Total Service Frequency (TSF)

Service frequency counts are reported for services relevant to the condition. MCOs capture each eligible member's services rendered during the measurement year for the following service categories: inpatient facility discharges, ED visits, and observation room stays. These categories and codes are similar to those in the *Inpatient Utilization—General Hospital/Acute Care* and *Ambulatory Care* Use of Service measures.

Refer to the *Calculating Standard Services Frequency* instructions in the Cost of Care Guidelines.

Sum and report all services in each service category by member cohort in Table RHY-1/2/3.

Inpatient Facility Discharges

This category measures the number of acute and non-acute inpatient facility discharges. Count each discharge once. Include data from any institution that provides long-term/specialty nonacute care.

Use Table RHY-C to report total discharges for each reporting category by member cohort (age and gender).

Table RHY-C: Codes to Identify Total Inpatient Discharges

ICD-9-CM Diagnosis	*WITH*	UB-92 Type of Bill
All principal diagnosis codes		11X, 12X, 41X, 42X, 84X

OR

DRG
1-432, 433, 439-455, 461, 463-471, 473, 475-540, 541-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code.

OR

Description	UB-92 Type of Bill	UB-92 Revenue	DRG
Hospice	81X, 82X	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	
SNF	21X, 22X	019X	
Hospital transitional care, swing bed or rehabilitation	18X		
Rehabilitation		0118, 0128, 0138, 0148, 0158	462
Respite		0655	

OR

Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)

ED Visits

This category measures use of ED services.

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. Do not count visits to urgent care centers.

Use the codes in Table AMB-B to identify ED visits. Services for members admitted to the hospital from an ED Visit should be included in the inpatient category only.

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Trends in utilization of observation rooms are an important aspect of total utilization data.

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. Use the codes in Table AMB-D to identify observation room visits. Services for members admitted to the hospital from an observation room stay should be included in the inpatient category only.

Note: *For members with multiple observation room or ED services on the same day, report each service that meets the measure criteria in the appropriate category. Report every instance of the code/service.*

Exclude from Observation Room Stays

- Claims with ED Revenue codes (Form Locator 42) of 45X and report them under *Emergency Department Visits.* ED visits that result in an observation room stay should be reported under *Emergency Department Visits.*
- Urgent care Revenue code (Form Locator 42) 456.
- Claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321, 323).
- UB-92 Revenue codes 0760 and 0769.

Table RHY-1/2/3: Relative Resource Use for People with Uncomplicated Hypertension—Commercial, Medicaid, Medicare (Report Separately)

Eligible Population

Eligible population _____

Medical Benefit Member Months

Member Months			
Age	**Male**	**Female**	**Total**
18-44	_____	_____	_____
45-54	_____	_____	_____
55-64	_____	_____	_____
65-75	_____	_____	_____
Unknown	_____	_____	_____
Total:	_____	_____	_____

Pharmacy Benefit Member Months

Member Months			
Age	**Male**	**Female**	**Total**
18-44	_____	_____	_____
45-54	_____	_____	_____
55-64	_____	_____	_____
65-75	_____	_____	_____
Unknown	_____	_____	_____
Total:	_____	_____	_____

Total Standard Price, by Service Category and Age and Gender

18-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-54	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
55-64	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
65-75	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

Service Frequency for Selected Services, by Specific Service and Age and Gender

18-44	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
45-54	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
55-64	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
65-75	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Unknown	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Total	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____

Relative Resource Use for People With Chronic Obstructive Pulmonary Disease (COPD) (RCO)

SUMMARY OF CHANGES TO HEDIS 2007

- For informational purposes only. This measure will not be collected for HEDIS 2007; it will be a first-year measure in HEDIS 2008.

Description

This measure reports the relative resource use, during the measurement year, for members with chronic obstructive pulmonary disease (COPD). Health plans calculate and report the eligible populations' total standard cost (based on a NCQA provided standard price table) and utilization by member cohort as instructed in the specification. Upon receiving and based on all health plan data NCQA will calculate *expected* (or average) total standard cost and utilization results (regional and national), after which health plans will receive their observed-to-expected ratio (or relative resource use ratio) for the clinical condition and each service category. When evaluated with the HEDIS *Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)* measure, the relative resource use ratios provide a better understanding of the efficiency or value of services rendered by the MCO.

See the Cost of Care Guidelines for definitions, methods to apply standard price to services and calculation processes.

Eligible Population

Note: *The eligible population is similar to the SPR measure's eligible population but does not apply the clean claim look back period and includes additional exclusions. The measure is further stratified into reporting categories in the Categorization of the Eligible Population section.*

Product lines	Commercial, Medicaid, Medicare.
Ages	42 years or older by December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary 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	Enrolled as of December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	Diagnosis of COPD. The MCO should follow the steps below to identify the eligible population, which is the denominator for the measure.
Step 1	Identify all members in the specified age range who during the measurement year had any diagnosis of COPD (Table SPR-A).
Step 2	Calculate continuous enrollment. Members must be continuously enrolled in the MCO during the measurement year.

Exclusions *(required)*

- Exclude from the eligible population members identified as having one or more of the following dominant conditions during the measurement year.
  - Active cancer
  - Organ transplant
  - ESRD
  - HIV/AIDS
- *For active cancer and ESRD,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a diagnosis code and with a procedure or revenue code listed in table RDI-A and RDI-B.
- *For organ transplant,* exclude members who had at least two face-to-face encounters with different dates of service during the measurement year with a procedure or revenue code listed in table RDI-C.
- *For HIV/AIDS,* exclude members who had at least two face-to-face encounters with different dates of service in an ambulatory or nonacute inpatient setting or at least one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year with a diagnosis code listed in tables RDI- D. Use the codes in Table RDI-E to identify the setting of care.

Categorization of Eligible Population

Major clinical condition

COPD.

Clinical category

None.

Comorbid categorization

Members in the eligible population with evidence of asthma, cardiovascular conditions, diabetes, depression or hypertension are identified to be "with comorbidity" for the measure. The MCO must use all methods to identify comorbid status; however, once a member meets the criteria for one condition, the MCO does not need to verify if the member has any of the remaining conditions listed. Follow the instructions for each comorbid condition.

Asthma

Step 1

Identify members as having persistent asthma who met at least one of the four criteria below, during the measurement year or the year prior to the measurement year.

- At least one ED visit (Tables ASM-A and ASM-B), with asthma as the principal diagnosis
- At least one acute inpatient discharge (Tables ASM-A and ASM-B), with asthma as the principal diagnosis
- At least four outpatient asthma visits (Tables ASM-A and ASM-B), with asthma as a listed diagnosis and at least two asthma medication dispensing events (Table ASM-C)
- A least four asthma medication dispensing events (i.e., an asthma medication was dispensed on four occasions) (Table ASM-C)

Step 2

- For a member identified as having persistent asthma because of at least four asthma medication dispensing events, where leukotriene modifiers were the sole asthma medication dispensed, the member must:

- Meet any of the other three criteria listed above in the same year as the leukotriene modifier, ***or***
- Have at least one diagnosis of asthma in any setting in the same year as the leukotriene modifier (i.e., measurement year or year prior to the measurement year).

Cardiovascular Conditions

Members are identified for cardiovascular condition comorbidity in one of two ways:

1. Event, ***or***

2. Diagnosis occurring during the measurement year or the year prior to the measurement year.

The MCO must use both criteria to identify comorbidity status.

Event. Discharged alive for AMI, CABG or PTCA. Use the codes listed in Table CMC-A to identify AMI, PTCA and CABG. AMI and CABG cases should be from inpatient claims only. All cases of PTCA should be included, regardless of setting (e.g., inpatient, outpatient, emergency room).

Diagnosis. At least one outpatient/nonacute inpatient or acute inpatient/ED visit with any diagnosis of IVD (Table CMC-B).

Diabetes

Two methods are provided to identify diabetic members:

1. Pharmacy data
2. Claim/encounter data.

The MCO must use both methods to identify the diabetics; however, a member only needs to be identified in one method to be included in the comorbid category. Members may be identified as having diabetes during the measurement year or the year prior to the measurement year.

Pharmacy data. Members who were dispensed insulin or oral hypoglycemics/ antihyperglycemics during the measurement year or year prior to the measurement year on an ambulatory basis. Refer to Table CDC-A.

Claim/encounter data. Members who had two face-to-face encounters with different dates of service in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year or the year prior to the measurement year with a diagnosis of diabetes. The MCO may count services that occur over both years.

Use the codes in Table CDC-B to identify ambulatory or nonacute inpatient and acute inpatient or ED encounters.

Major Depression

Identify all eligible members with a diagnosis of depression who, during the measurement year or year prior had:

- At least one principal diagnosis of major depression (refer to Table AMM-A) in any setting (e.g., outpatient visits, emergency room visits, inpatient discharges or partial hospitalizations), ***or***
- At least two secondary diagnoses of major depression (refer to Table AMM-A) on different dates of service in any outpatient setting (e.g., outpatient or emergency room visits), ***or***

- At least one secondary diagnosis of major depression (refer to Table AMM-A) associated with any inpatient discharge.

Note: *Lab claims should not be included in the identification of members with depression.*

Hypertension

Identify eligible members with hypertension. A member is considered hypertensive if there are at least two outpatient encounters (Table RDI-H) on different dates of service during the measurement year or the year prior to the measurement year with a diagnosis of hypertension (Table RDI-G). Codes in Table RDI-G must occur in conjunction with codes in Table RDI-H to count.

Reporting categories

- COPD, With Comorbidity
- COPD, Without Comorbidity

Note: *Assign each member to only one reporting category based whether they have one of the comorbidities previously listed.*

Standard Price Calculations

The measure reports total standard costs, which are assigned by matching codes for services rendered to the eligible population during the measurement year to codes listed in NCQA's Standard Price Tables (tables will be posted on NCQA's Web site at www.ncqa.org by December 1, 2006).

The health plan should sum and report standard prices for the services rendered to members in the eligible population during the measurement year by *reporting category*.

Total Standard Price (TSP)

Standard Price Tables (SPT) categorize services into one of the following.

- Inpatient Facility
- Evaluation and Management (E&M)
- Procedures and Surgery (inpatient and outpatient)
- Pharmacy

Capture all services rendered to members in the eligible population during the measurement year. Using the codes listed in the appropriate SPT table categorize these services into one of the service categories listed above. Count each distinct service rendered to the eligible member. To assign standard price to rendered services, link the services to the NCQA Total Standard Price table, which list the assigned standard price.

Within each service category listed in Table RCO-A if a member's price exceeds the service category "cap" amount, then truncate the member's total standard price as listed in the table. For example, if an eligible member total inpatient standard price was $97,000 during the measurement year cap the member's total inpatient standard price at $75,000.

Table RCO-A: Identifying Service Category's Truncation Amounts

Service	Cap Amount
Inpatient Facility	$75,000
E&M	$15,000
Surgery (inpatient and outpatient)	$25,000
Pharmacy	$15,000

Note: Do not exclude members who exceed the capped amount.

Sum and report the total standard cost for the eligible population in each service category by member cohort in Tables RCO-1/2/3.

See the *Calculating Standard Price* instructions in the Cost of Care Guidelines for steps to categorize service data rendered for each service category and linking service data to NCQA SPT tables.

Selected Frequency Services Calculations

Total Service Frequency (TSF)

Service frequency counts are reported for services relevant to the condition. MCOs capture each eligible member's services rendered during the measurement year for the following service categories: inpatient facility discharges, ED visits, and observation room stays. These categories and codes are similar or the same as those in the Inpatient-Utilization—General Hospital/Acute Care (IPU) and Ambulatory Care (AMB) UOS measures.

Refer to the *Calculating Standard Services Frequency* instructions in the Cost of Care Guidelines.

Sum and report the all services in each service category by member cohort in Tables RCO-1/2/3.

Inpatient Facility Discharges

This category measures the number of acute and non-acute inpatient facility discharges. Count each discharge once. Include data from any institution that provides long-term/specialty nonacute care.

Use Table RCO-B to report total discharges for each reporting category by member cohort (age and gender).

Table RCO-B: Codes to Identify Total Inpatient Discharges (Acute and Nonacute)

ICD-9-CM Diagnosis	*WITH*	UB-92 Type of Bill
All principal diagnosis codes		11X, 12X, 41X, 42X, 84X

OR

DRG
1-432, 433, 439-455, 461, 463-471, 473, 475-540, 541-559

OR

ICD-9-CM Diagnosis
All principal diagnosis codes with an inpatient facility code.

OR

Description	UB-92 Type of Bill	UB-92 Revenue	DRG
Hospice	81X, 82X	0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659	
SNF	21X, 22X	019X	
Hospital transitional care, swing bed or rehabilitation	18X		
Rehabilitation		0118, 0128, 0138, 0148, 0158	462
Respite		0655	

OR

Other nonacute care facilities that do not use the UB-92 for billing (e.g., ICF, SNF)

ED Visits

This category measures use of ED services.

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. Do not count visits to urgent care centers.

Use the codes in Table AMB-B to identify ED visits. Services for members admitted to the hospital from an ED Visit should be included in the inpatient category only.

Observation Room Stays

This category measures observation room stays that result in discharge of the patient. Trends in utilization of observation rooms are an important aspect of total utilization data and total cost.

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. Use the codes in Table AMB-D to identify observation room visits. Services for members admitted to the hospital from an observation room stay should be included in the inpatient category only.

Note: *For members with multiple observation room or ED services on the same day, report each service that meets the measure criteria in the appropriate category. Report every instance of the code/service.*

Exclude from Observation Room Stays

- Claims with ED Revenue codes (Form Locator 42) of 45X and report them under *Emergency Department Visits.* ED visits that result in an observation room stay should be reported under *Emergency Department Visits.*
- Claims with ambulatory surgery Revenue codes (Form Locator 42 of 36X, 49X, 75X, 79X, 480, 481, 320, 321, 323)
- UB-92 Revenue codes 0760 and 0769.

Table RCO-1/2/3: Relative Resource Use for People with Chronic Obstructive Pulmonary Disease (COPD)—Commercial, Medicaid, Medicare (Report Separately)

Eligible Population

Eligible Population With Comorbidity	_____
Eligible Population Without Comorbidity	_____

Medical Benefit Member Months

Member Months (With Comorbidity)				Member Months (Without Comorbidity)		
Age	Male	Female	Total	Male	Female	Total
42-44						
45-64						
65-75						
75+						
Unknown						
Total:						

Pharmacy Benefit Member Months

Member Months (With Comorbidity)				Member Months (Without Comorbidity)		
Age	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**
42-44	_____	_____	_____	_____	_____	_____
45-64	_____	_____	_____	_____	_____	_____
65-75	_____	_____	_____	_____	_____	_____
75+	_____	_____	_____	_____	_____	_____
Unknown	_____	_____	_____	_____	_____	_____
Total:	_____	_____	_____	_____	_____	_____

Total Standard Price, by Service Category and Age and Gender (Reported by COPD With Comorbidity)

42-44	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
45-64	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
65-75	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
75+	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Unknown	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____
Total	Male	_____	_____	_____	_____
	Female	_____	_____	_____	_____
	Total:	_____	_____	_____	_____

Service Frequency for Selected Services, by Specific Service and Age and Gender (Reported by COPD with Comorbidity)

42-44	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
45-64	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
65-75	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
75+	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Unknown	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____
Total	Male	_____	_____	_____
	Female	_____	_____	_____
	Total:	_____	_____	_____