Table 6A: Selected Diagnoses and Services Rendered

PURPOSE:

Table 6A is part of the clinical profile that collects data on selected diagnoses and selected services rendered to health center patients. It reports on medical, mental health, substance use disorder, vision, dental, patient support, and upstream drivers of health diagnoses and services. It is designed to give information on diagnoses and services using data maintained for billing purposes, laboratory reports, and/or other information captured in your health information technology (health IT) systems or electronic health records (EHRs).

The selected diagnoses and services represent those that are prevalent among Health Center Program patients, have been regarded as sentinel indicators of access to primary care, and/or are of special interest to the Health Resources and Services Administration.

CHANGES:

Several key changes have been made to Table 6A, as outlined below:

- Some diagnosis and service codes have been updated. All code changes are reflected in this table and detailed in the "Table 6A Code Changes" file available on the UDS Clinical Care resources webpage.
- Eleven selected diagnoses and services lines have been removed: respiratory conditions related to COVID-19 (Line 6a), abnormal breast cancer findings, female (Line 7), abnormal cervical findings (Line 8), contact dermatitis and other eczema (Line 12), novel coronavirus (SARS-CoV-2) diagnostic test (Line 21c), novel coronavirus (SARS-CoV-2) antibody test (Line 21d), mammogram (Line 22), Pap test (Line 23), sealants (Line 30), oral surgery (extractions and other surgical procedures) (Line 33), rehabilitative services (Endo, Perio, Prostho, Ortho) (Line 34).
- Eleven new lines have been added: diabetes mellitus type 1 (Line 9a), intellectual and developmental disabilities (IDD) (Line 20g), autism spectrum disorder (ASD) screening (Line 26g), case management (Line 35), eligibility assistance (Line 36), transportation (Line 37), language assistance services (Line 38), upstream drivers of health screening (Line 39), food insecurity (Line 40), housing instability (Line 41), and financial insecurity (Line 42).
- Health supervision of infant or child (ages 0 through 11) (Line 26) has been renamed to Well child visit (ages 0 through 11).
- Some elements of the Other Data Elements Form outreach and enrollment assists have been added to the Selected Patient Support Services and Selected Upstream Drivers of Health Services section.

KEY TERMS:

SELECTED DIAGNOSES (LINES 1–20G)

Visits (Column A): Report the total number of visits (clinic [in-person] and virtual) during the calendar year for which one or more of the listed diagnoses is diagnosed or treated and documented in the health IT/EHR or visit/billing record.

Patients (Column B): Report each patient who had one or more visits (clinic [in-person] and/or virtual) during the calendar year that were reported in the corresponding cell in Column A.

SELECTED TESTS/SCREENING (LINES 21–26G & LINES 35–42)

Visits (Column A): Report the total number of visits (clinic [in-person] and/or virtual) during which one or more of the listed diagnostic tests, screenings, preventive services, patient support services, and/or upstream drivers of health services were provided during the year. Services may have been provided at the time of a visit, before a visit, or after a visit.

Patients (Column B): Report patients who had one or more visits (clinic [in-person] and/or virtual) during the calendar year for which one or more of the selected diagnostic tests, screenings, and/or preventive services listed on Lines 21–26g and Lines 25-42 were provided.

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DENTAL SERVICES (LINES 27–32)

Visits (Column A): Report the total number of visits (clinic [in-person] and/or virtual) for which one or more of the listed diagnostic tests, screenings, and/ or dental services were provided during the year. Services may be at the time of a visit, before a visit, or after a visit.

Patients (Column B): Report patients who had at least one visit with a dental professional during the calendar year for each of the selected dental services listed.

PATIENT SUPPORT SERVICES AND UPSTREAM DRIVERS OF HEALTH (LINES 35–42)

Selected Patient Support Services (Lines 35–38): Only visits and patients that include the direct provision of the indicated patient support services (not referral or education alone) are to be counted.

Selected Upstream Drivers of Health Services (Lines 39–42): Upstream drivers of health screening (Line 39) includes use of a standardized screener to screen for upstream drivers of health. Lines 40 through 42 include the provision of services to address food insecurity, housing instability, and financial insecurity, respectively.

WHAT THE DATA HELP US UNDERSTAND:

To calculate:

- The average visits per patient per year for a particular condition and/or service—divide Column A by Column B (e.g., number of diabetes visits per diabetic patient per year).
- The frequency of acute care services by service type (e.g., well child immunizations).
- The proportion of patients who received recommended, appropriate routine preventive services (e.g., pediatric patients who received Well child visits).
- Proportion of patients receiving tests, screenings, patient support services, or upstream drivers of health services of a selected group (e.g., percentage of patients screened for ASD; percentage of women who receive contraceptive services of women age 15–44).

CROSS-TABLE CONSIDERATIONS:

- If you submit Grant Reports, the total number of patients and visits reported on a Grant Report must be less than or equal to the corresponding number on the Universal Report for each cell.
- The count of patients by diagnosis reported on Table 6A will not be the same count as on Tables 6B and 7, due to differences in criteria that must be met for inclusion on Tables 6B or 7. Specifically:
  - All patients, regardless of age, seen for reportable services and diagnoses are included on Table 6A, but Tables 6B and 7 relate only to patients of specific age ranges.
  - Table 6A asks about selected diagnoses and services during the calendar year, but in Tables 6B and 7, measures may require patients to be considered based on active diagnoses or a look-back period of completed services.
  - Codes used for metrics across the two tables may differ.

TABLE TIPS:

Table 6A is completed for the Universal Report and the Grant Reports (if applicable).

SELECTED DIAGNOSES (LINES 1–20g):

- Report visits and patients regardless of whether the diagnosis is primary.
- Report each included diagnosis made at a visit, regardless of the number of diagnoses listed for the visit (e.g., count a patient visit with a diagnosis of hypertension and a diagnosis of diabetes once on Line 9 [and Line 9a if it is type 1] and once on Line 11 for hypertension).
- Include follow-up services related to a countable visit. (e.g., if a provider asks a patient to return in 30 days for a flu shot, when that patient presents,

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the shot is counted because the patient was seen during the year for a countable visit).

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SELECTED TESTS/SCREENINGS (LINES 21–26g & LINES 35–42):

- Lines 21 through 26g and Lines 35–42 present the name and applicable ICD-10-CM diagnostic, HCPCS, CPT procedure, and/or SNOMED CT codes and/or value sets for selected tests, procedures, screenings, preventive services, patient support services, and upstream drivers of health services. For each line, report visits that are associated with a qualifying code from any of these code systems. For example, count only one visit even if there is a qualifying CPT code and a qualifying ICD-10-CM code.
- On several lines, HCPCS, CPT codes and ICD-10-CM codes are provided. Health centers may use ***either*** HCPCS, CPT codes ***or*** the ICD-10-CM codes for any specific visit, ***but not*** all code types.
- A single visit may include multiple types of services. Report each on the applicable line (e.g., if a patient had an HIV test and contraceptive management during the same visit, this patient would be counted on both Lines 21 and 25).
- A visit is counted only once for any one service code even if multiple services are given (e.g., five vaccines or two fillings in one visit are counted only once).

Note: ICD-10-CM codes for some services (such as childhood lead test screening or smoke and tobacco use cessation counseling) are listed to ensure capture of tests that are done by the health center but may be coded with a different CPT code for state reimbursement. In some instances, payers (especially governmental payers) and laboratories ask health centers to use different codes for services. In these instances, health centers should internally map these codes to the specified list for reporting purposes.

- Line 21e, pre-exposure prophylaxis (PrEP)-associated prescribing and management:
  - Use code Z29.81 for PrEP prescribed to patients for the purposes of preventing HIV.
- Report only patients with an active prescription for PrEP based on a patient's risk for HIV exposure.
- Count PrEP only if the following medications are prescribed: emtricitabine/tenofovir disoproxil fumarate (FTC/TDF), emtricitabine/tenofovir alafenamide (FTC/TAF), cabotegravir, or lenacapavir for the purposes of preventing HIV.

DENTAL SERVICES (LINES 27–32):

- Lines 27 through 34 present the name and applicable American Dental Association (ADA) procedure codes for selected dental services.
- During one visit, more than one service may be provided. Report each on their separate, applicable line. If they are on the same line, report only one visit (e.g., if patient had more than one tooth filled during a visit, report only one visit for restorative services [Line 32], not one visit per tooth).
- Do not report fluoride treatments or varnishes that are applied outside of a comprehensive plan, including when provided as part of a community service at schools, on this table or as a visit on Table 5.

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SELECTED PATIENT SUPPORT SERVICES (LINES 35–38):

- Only visits and patients that include the direct provision of the indicated patient support services (and not referral or education alone) are to be counted.
- For each line, report visits that are associated with a qualifying code from any of the specified code systems. Count only one visit per line, even if multiple qualifying codes exist for that service during the visit.
- When more than one service is provided during a single visit, report each on its applicable line (such as reporting a visit on both Line 21 for an HIV test and Line 35 for case management).
- Report each patient only once per line in Column B, regardless of the number of visits made for that specific patient support service during the calendar year.

SELECTED UPSTREAM DRIVERS OF HEALTH SERVICES (LINES 39–42)

- For each line, report visits during the calendar year that are associated with a qualifying code from any of the specified code systems. Only services provided to patients who had one or more countable visits during the year are to be reported.
- During a single visit, if a patient receives screening and/or multiple upstream drivers of health services, report each on its applicable line. If multiple qualifying codes for the same line exist during a single visit, count only one visit on that line.
- Report each patient only once per line in Column B, regardless of the number of visits or screenings made for that specific upstream driver service during the calendar year.

SERVICES PROVIDED BY MULTIPLE ENTITIES

- Report the service if a health center provider orders and performs the service.
- If the health center provider orders a test (e.g., HIV test) and the sample is collected at the health center and then sent to a reference lab for processing, report the test regardless of whether the test is paid for by the patient, the patient's insurance company, a government entity, or the health center.
- Report a test when the health center provider asks a patient to get that test from a third party and the health center provider receives and reviews the test results with or for the patient (e.g., report mammograms performed by a third-party provider that a health center contracts with and for which the health center reviews the result with the patient).

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SELECTED CALCULATION:

Shown below, average number of diabetes mellitus (DM) diagnosis visits per patient per year = 30,090/9,928 = 3.0 DM visits/patient/year. See Table 6A example below.

TABLE 6A: SELECTED DIAGNOSES AND SERVICES RENDERED				
Line	**Diagnostic Category**	**Applicable ICD-10-CM Code or Value Set Object Identifier (OID)**	**Number of Visits by Diagnosis Regardless of Primacy (A)**	**Number of Patients with Diagnosis (B)**
Selected Other Medical Conditions				
9	Diabetes mellitus	**ICD-10:** E08- through E13-, O24- (exclude O24.4-) **OID:** 2.16.840.1.113762.1.4.1219.33	30,090	9,928
9a	Diabetes mellitus type 1	**ICD-10:** E10-	[Report subset]	[Report subset]

CROSS-TABLE CONSIDERATION EXAMPLE:

Compare this to Table 7, Section C, Line i, Column 3A (see next page): Total patients ages 18-75 with diabetes. This number is only 8,905 because these are patients who meet all of the following criteria:

- Diagnosed with an active diagnosis of type 1 or type 2 diabetes.
- Had at least one medical visit (clinic [in-person] or virtual) during the measurement year.
- Did **not** have secondary diabetes (e.g., gestational diabetes).

In other words, the count of patients by diagnosis reported on Table 6A will not be the same count as on Table 7 due to differences in criteria that must be met for inclusion on Table 7:

1. All patients, regardless of age, seen for all reportable services and diagnoses, are included on Table 6A, but Table 7 relates only to patients of specific age ranges (ages 18 through 75 for diabetes).
2. Table 6A reports selected diagnoses and services rendered during the calendar year, whereas Table 7 requires patients to be evaluated based on active diagnoses or qualifying encounters.
3. Codes and exclusions (such as patients receiving hospice care during the measurement period) used for metrics across the two tables may differ.

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CROSS-TABLE CONSIDERATION EXAMPLE: (CONTINUED)

TABLE 7 SECTION C: DIABETES: GLYCEMIC STATUS ASSESSMENT GREATER THAN 9%				
Line	**Race and Ethnicity**	**Total Patients 18 through 75 Years of Age with Diabetes (3A)**	**Number of Records Reviewed (3B)**	**Patients with Glycemic Status Assessment 9%, Missing, or No Test During the Year (3F)**
MEXICAN, MEXICAN AMERICAN, CHICANO/A				
	Subtotal Mexican, Mexican American, Chicano/a	752	752	243
PUERTO RICAN				
	Subtotal Puerto Rican	247	247	86
CUBAN				
	Subtotal Cuban	1,023	1,023	306
ANOTHER HISPANIC, LATINO/A, OR SPANISH ORIGIN				
	Subtotal Another Hispanic or Latino/a, or Spanish Origin	430	430	148
HISPANIC, LATINO/A, SPANISH ORIGIN COMBINED				
	Subtotal Hispanic, Latino/a, or Spanish Origin Combined	347	347	42
NOT HISPANIC, LATINO/A, OR SPANISH ORIGIN				
	Subtotal Not Hispanic or Latino/a or Spanish Origin	6,106	6,106	1,938
UNREPORTED/CHOSE NOT TO DISCLOSE RACE AND ETHNICITY				
h	Unreported/Chose Not to Disclose Race and Ethnicity	414	414	111
i	***Total***	8,905	8,905	2,763