

Acute Hospital Utilization (AHU)*

**This is a risk-adjusted utilization measure that compares observed to expected rates. The exact risk weights that will be used for this measure in this Innovation Center model will be determined at a date closer to implementation. Therefore, NCQA is providing access to the specifications without the risk weights needed for calculating expected values.*

Measure title	Acute Hospital Utilization	Measure ID	AHU
Description	For persons 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement period.		
Measurement period	January 1–December 31.		
Copyright and disclaimer notice	Refer to the complete copyright and disclaimer information at the front of this publication. NCQA website: www.ncqa.org . Submit policy clarification support questions via My NCQA (https://my.ncqa.org).		
Clinical recommendation statement/ rationale	Hospitalizations put patients at risk of adverse events and are costly, accounting for about a third of all annual health care expenditures in the US. While not all acute hospitalizations can be avoided, studies have shown that payer-level interventions (e.g., proper care coordination and case management for patients with complex medical needs or multiple comorbid conditions) are effective at reducing overall hospital utilization. Refer to the HEDIS Measure Library & Historical Data measure web page for additional information about the clinical rationale.		
Citations	Covinsky, K.E., E. Pierluissi, & C.B. Johnston. 2011. “Hospitalization-Associated Disability.” <i>JAMA: The Journal of the American Medical Association</i> 306(16), 1782–93. McDermott, K.W., A. Elixhauser, R. Sun. 2017. “Trends in Hospital Inpatient Stays in the United States, 2005–2014.” HCUP Statistical Brief #225. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb225-Inpatient-US-Stays-Trends.pdf Mkanta, W.N., N.R. Chumbler, K. Yang, R. Saigal, and M. Abdollahi. 2016. “Cost and Predictors of Hospitalizations for Ambulatory Care - Sensitive Conditions Among Medicaid Enrollees in Comprehensive Managed Care Plans.” <i>Health Services Research and Managerial Epidemiology</i> 3, 2333392816670301. Kaiser Family Foundation (KFF). (2019). <i>An Overview of Medicare</i> . https://www.kff.org/medicare/issue-brief/an-overview-of-medicare/		
Characteristics			
Scoring	Ratio.		

Product lines	• Commercial. • Medicare. • Medicaid.
Stratifications	Age as of the last day of the measurement period for Medicaid. • 18–21 years. • 22–34 years. • 35–44 years. • 45–54 years. • 55–64 years. Age as of the last day of the measurement period for commercial and Medicare. • 18–44 years. • 45–54 years. • 55–64 years. • 65–74 years. • 75–84 years. • 85+ years.
Guidance	Programming Guidance Dual enrollment: Persons with dual commercial and Medicaid enrollment may only be reported in the commercial product line. Persons with dual Medicaid/Medicare enrollment may only be reported in the Medicare product line. Dual enrollment is assessed after the continuous enrollment criteria are applied. To meet criteria for dual enrollment, persons must have dual enrollment at the end of the continuous enrollment period. Risk Adjustment Measure-Specific Guidance Observation stays: For observation stays (<u>Observation Stay Value Set</u>) that do not have a recorded admission or discharge date, set the admission date to the earliest date of service on the claim and set the discharge date to the last date of service on the claim. Which services count? • Use all paid, suspended, pending, and denied claims when applying risk adjustment comorbidity category determination and the hospice exclusion. • Do not include denied claims when identifying all other events (e.g., observed events); only report claims the organization paid for or expects to pay for (i.e., claims incurred but not paid). Supplemental data exceptions: Supplemental data may only be used for the hospice exclusion. Transfers: • Treat transfers <i>between</i> institutions as separate admissions. • Base transfer reports <i>within</i> an institution on the type and level of services

	provided.
	• Report separate admissions when the transfer is between acute and nonacute levels of service or between mental health/substance use disorder treatment services and non-mental health/substance use disorder treatment services. • Count only one admission when the transfer takes place within the same service category, but to a different level of care (e.g., from intensive care to a lesser level of care; from a lesser level of care to intensive care). Risk adjustment: Organizations may not use risk assessment protocols to supplement diagnoses for calculation of the risk adjustment scores for these measures. The measurement model was developed and tested using only claims-based diagnoses; diagnoses from additional data sources would affect the validity of the models as they are currently implemented in the specification. General Rules Data collection methodology: Administrative. (Refer to General Guideline Data Collection Methods for additional information.) Date specificity: Dates must be specific enough to determine the event occurred in the period being measured. Improvement notation: To interpret the ratio as better or worse than expected, the ratio must be calibrated. Organizations can calibrate ratios by dividing individual organization ratios or national percentiles by the national average ratio. Organizations may be more successful at achieving fewer hospitalizations than expected, given the types of cases treated by the organization (calibrated ratio with a value <1.0), or may be less successful (calibrated ratio with a value >1.0).
Definitions	
Direct transfer	When the discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less. • <i>For example:</i> – A discharge on June 1, followed by a subsequent admission on June 1 or June 2, <i>is a direct transfer</i>. – A discharge on June 1, followed by a subsequent admission on June 3, <i>is not a direct transfer</i>; these are two distinct stays. – A discharge on June 1, followed by a subsequent admission on June 2 (with discharge on June 3), followed by a subsequent admission on June 4, <i>is a direct transfer</i>. Direct transfers may occur between different facilities, and between acute inpatient and observation.
Outlier	Medicare enrollees with four or more inpatient or observation stay discharges during the measurement period. Medicaid enrollees with six or more inpatient or observation stay discharges during the measurement period. Commercial enrollees with three or more inpatient or observation stay

	discharges during the measurement period.
Nonoutlier	Medicare enrollees with three or fewer inpatient or observation stay discharges during the measurement period. Medicaid enrollees with five or fewer inpatient or observation stay discharges during the measurement period. Commercial enrollees with two or fewer inpatient or observation stay discharges during the measurement period.
Planned hospital stay	A hospital stay is considered planned if it meets criteria in step 3 of the measure observation.
PPD	Predicted probability of discharge. The predicted probability of a person having any discharge in the measurement period.
PUCD	Predicted unconditional count of discharges. The predicted unconditional count of discharges for persons during the measurement period.
Initial population	<i>Measure item count:</i> Person. <i>Attribution basis:</i> Enrollment. • <i>Benefits:</i> Medical. • <i>Continuous enrollment:</i> The measurement period and the year prior to the measurement period. • <i>Allowable gap:</i> No more than one gap of ≤45 days during each year of continuous enrollment. No gap on the last day of the measurement period. <i>Ages:</i> • <i>Commercial and Medicare:</i> 18 years of age and older as of the last day of the measurement period. • <i>Medicaid:</i> 18–64 years of age as of the last day of the measurement period. <i>Gender/Sex criteria:</i> • Administrative Gender of Female (AdministrativeGender code female). • Administrative Gender of Male (AdministrativeGender code male). Exclusion: Persons in hospice or using hospice services. Persons who use hospice services (Hospice Encounter Value Set; Hospice Intervention Value Set) or elect to use a hospice benefit any time during the measurement period. Organizations that use the Monthly Membership Detail Data File to identify these persons must use only the run date of the file.
Measure observation	Calculation of observed events Use the following steps to identify and categorize acute inpatient and observation stay discharges. Step 1. Identify all acute inpatient and observation stay discharges during the measurement period. 1. Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>)

	and observation stays (<u>Observation Stay Value Set</u>).
	2. Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). 3. Identify the discharge date for the stay. Step 2. For discharges with one or more direct transfers, use the last discharge. Using the discharges identified in step 1, identify direct transfers between acute inpatient and observation using the definition of direct transfer. Step 3. For the remaining acute inpatient and observation stay discharges, exclude inpatient and observation stay discharges for any of the following criteria: • A principal diagnosis of mental health or substance use disorder (<u>Mental and Behavioral Disorders Value Set</u>) on the discharge claim. • A principal diagnosis of live-born infant (<u>Deliveries Infant Record Value Set</u>) or maternity-related principal diagnosis (<u>Maternity Diagnosis Value Set</u>) on the discharge claim. • A maternity-related stay (<u>Maternity Value Set</u>) on the discharge claim. • A planned hospital stay using any of the following on the discharge claim: – A principal diagnosis of maintenance chemotherapy (<u>Chemotherapy Encounter Value Set</u>). – A principal diagnosis of rehabilitation (<u>Rehabilitation Value Set</u>). – An organ transplant (<u>Kidney Transplant Value Set</u>, <u>Bone Marrow Transplant Value Set</u>, <u>Organ Transplant Other Than Kidney Value Set</u>, <u>Introduction of Autologous Pancreatic Cells Value Set</u>). – A potentially planned procedure (<u>Potentially Planned Procedures Value Set</u>) without a principal acute diagnosis (<u>Acute Condition Value Set</u>). • The person died during the stay. Note: For hospital stays where there was a direct transfer (identified in step 2), use the original stay and any direct transfer stays to identify exclusions in this step. Step 4. Remove discharges for outliers and report these persons as outliers. Count discharges with one or more direct transfers (identified in step 2) as one discharge when identifying outliers. Step 5. Calculate the total using all discharges identified after completing steps 1–4.
Risk adjustment factors	<i>Risk Adjustment Determination</i> For each discharge among nonoutliers, identify risk adjustment weights based on comorbidity, age and gender. Weights are specific to product line (Medicare Under 65, Medicare 65 Plus, Medicaid, commercial). Refer to the reporting indicator column in the risk adjustment tables to ensure that weights are linked appropriately. Comorbidities: Step 1. Identify all diagnoses for encounters during the year prior to the measurement period. Include the following when identifying encounters:

- Outpatient visits, ED visits, telephone visits, nonacute inpatient encounters and acute inpatient encounters (Outpatient, ED, Telephone, Acute Inpatient and Nonacute Inpatient Value Set) with a date of service during the year prior to the measurement period.
- Acute and nonacute inpatient discharges (Inpatient Stay Value Set) with a discharge date during the year prior to the measurement period.

Step 2. Assign each diagnosis to one or more comorbid condition category (CC) using Table CC—Mapping in the Risk Adjustment Shared Tables. If the code appears more than once in Table CC—Mapping, it is assigned to multiple CCs.

Exclude all diagnoses that cannot be assigned to a comorbid CC. For persons with no qualifying diagnoses from face-to-face encounters, skip to Risk Adjustment Calculation.

All digits must match exactly when mapping diagnosis codes to the comorbid CCs.

Step 3. Determine the hierarchical condition category (HCC) for each comorbid CC identified. Refer to Table HCC—Rank.

For each person's comorbid CC list, match the comorbid CC code to the comorbid CC code in the table, and assign:

- The ranking group.
- The rank.
- The HCC.

For comorbid CCs that do not match to Table HCC—Rank, use the comorbid CC as the HCC and assign a rank of 1. One comorbid CC can map to multiple HCCs; each HCC can have one or more comorbid CCs.

Step 4. Assess each ranking group separately and select only the highest ranked HCC in each ranking group using the "Rank" column (1 is the highest rank possible).

Drop all other HCCs in each ranking group, and de-duplicate the HCC list if necessary.

- *For example*, assume a person with the following comorbid CCs: CC-85, CC-17 and CC-19 (assume no other CCs).
 - CC-85 does not have a map to the ranking table and becomes HCC-85.
 - HCC-17 and HCC-19 are part of Diabetes Ranking Group 1. Because CC-17 is ranked higher than CC-19 in Ranking Group Diabetes 1, the comorbidity is assigned as HCC-17 for Ranking Group 1.

The final comorbidities for this person are HCC-17 and HCC-85.

Table HCC—Rank

Ranking Group	CC	Description	Rank	HCC
NA	CC-85	Congestive Heart Failure	NA	HCC-85
Diabetes 1	CC-17	Diabetes With Acute Complications	1	HCC-17
	CC-18	Diabetes With Chronic Complications	2	HCC-18
	CC-19	Diabetes Without Complications	3	HCC-19

Step 5. Identify combination HCCs listed in Table HCC—Comb.

Some combinations suggest a greater amount of risk when observed together. For example, when diabetes *and* CHF are present, an increased amount of risk is evident. Additional HCCs are selected to account for these relationships.

Compare each person's list of unique HCCs to those in the *Comorbid HCC* columns in Table HCC—Comb and assign any additional HCCs.

If there are overlapping combinations, use both sets of combinations. Based on the combinations, a person can have none, one or more of these added HCCs.

- *For example*, for a person with comorbidities HCC-17 and HCC-85 (assume no other HCCs), assign HCC-901 in addition to HCC-17 and HCC-85. This does not replace HCC-17 and HCC-85.

Table HCC—Comb

Comorbid HCC 1	Comorbid HCC 2	Comorbid HCC 3	HCC-Combination	HCC-Comb Description
HCC-17	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-18	HCC-85	NA	HCC-901	Combination: Diabetes and CHF
HCC-19	HCC-85	NA	HCC-901	Combination: Diabetes and CHF

Risk adjustment**Risk Adjustment Calculation**

Calculation of risk-adjusted outcomes (counts of discharges) uses predetermined risk weights generated by two separate regression models. Weights from each model are combined to predict how many visits each person might have during the measurement period.

For each nonoutlier person in the initial population, assign PPD risk weights. Calculate the PPD.

Step 1. For each person with a comorbidity HCC, link the PPD weights.

Step 2. Link the age-gender PPD weights for each person.

Step 3. Sum all PPD weights (comorbidities, age and gender) associated with the person.

Step 4. Calculate the predicted probability of having at least one discharge in the measurement period based on the sum of the weights for each person using the formula below.

$$PPD = \frac{e^{(\sum PPD \text{ WeightsForEachPerson})}}{1 + e^{(\sum PPD \text{ WeightsForEachPerson})}}$$

Truncate the final PPD *for each person* to 10 decimal places. Do not truncate or round in previous steps.

For each nonoutlier person in the initial population, assign PUCD risk weights.

Step 1. For each person with a comorbidity HCC, link the PUCD weights. If a person does not have any comorbidities to which a weight could be linked, assign a weight of 1.

Step 2. Link the age-gender PUCD weights for each person.

Step 3. Calculate the predicted unconditional count of discharges in the measurement period by multiplying all PUCD weights (comorbidities, age and gender) associated with the person. Use the following formula:

$$PUCD = \text{Age/Gender Weight} * \text{HCC Weight}$$

Note: Multiply by each HCC associated with the person. For example, assume a person with HCC-2, HCC-10, HCC-47. The formula would be:

$$PUCD = \text{Age/Gender Weight} * \text{HCC-2} * \text{HCC-10} * \text{HCC-47}$$

Truncate the final PUCD *for each person* to 10 decimal places. Do not truncate or round in previous steps.

Expected count of discharges. Calculate the final person-level expected count of discharges using the formula below.

$$\text{Expected Count of Discharges} = PPD \times PUCD$$

Round the person-level results to 4 decimal places using the .5 rule and sum over all persons in the category.

Step 4. Use the formula below to calculate the covariance of the predicted outcomes for each category. For categories with a single person ($n_c=1$), set the covariance to zero. Do not round the covariance before using it in step 5.

$$COV_c = \frac{\sum_{m=1}^{n_c} (PPD_m - \text{mean}(PPD)_c) \times (PUCD_m - \text{mean}(PUCD)_c)}{n_c - 1}$$

Where:

c denotes an individual category

n_c is the number of persons in the category indicated by c

m is an individual person within the category indicated by c

PPD_m is the truncated PPD for the person denoted by m

$\text{mean}(PPD)_c$ is the unrounded and untruncated mean PPD in the category indicated by c

$PUCD_m$ is the truncated PUCD for the person denoted by m

$\text{mean}(PUCD)_c$ is the unrounded and untruncated mean PUCD in the category indicated by c

Step 5. Once the covariance between PPD and PUCD for a given category is calculated, it can be used as indicated in the formula below to calculate the variance for that category.

	$Variance_c = \sum_{m=1}^{n_c} (PPD_m \times PUCD_m)^2 \times \left(1 + (1 - PPD_m)^2 + \left(\frac{2 \times COV_c}{PPD_m \times PUCD_m} \right) \right)$ Where: c denotes an individual category n_c is the number of persons in the category indicated by c m is an individual person within the category indicated by c PPD_m is the truncated PPD for the person denoted by m $PUCD_m$ is the truncated PUCD for the person denoted by m Round the variance for reporting to 4 decimal places using the .5 rule.
Summary of changes	• Replaced references to “chemical dependency” with “substance use disorder.” • Replaced references to “CC” with “condition category”; replaced references to “HCC” with “hierarchical condition category.” • Revised step 3 of the denominator to clarify exclusion of inpatient and observation stay discharges where the person died during the stay.
Data element tables	Reporting: Number of nonoutliers The number of nonoutlier persons for each age group, reported as the NonOutlierPersonCount. Reporting: Number of outliers The number of outlier persons for each age group, reported as the OutlierPersonCount. Calculated: Number of persons in the initial population The number of persons in the initial population (including outliers) for each age group and totals. Calculated by IDSS as the PersonCount. Calculated: Outlier rate The number of outlier persons (OutlierPersonCount) divided by the number of persons in the initial population (PersonCount) multiplied by 1,000 for each age group and totals. Calculated by IDSS as the OutlierRate. Reporting: Number of observed events among nonoutlier persons The number of observed discharges within each age group, reported as the ObservedCount. Calculated: Observed discharges per 1,000 nonoutlier persons The number of observed discharges (ObservedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 within each age group and totals. Calculated by IDSS as the ObservedRate. Reporting: Number of expected events among nonoutlier persons The number of expected discharges within each age group, reported as the ExpectedCount.

Calculated: Expected discharges per 1,000 nonoutlier persons

The number of expected discharges (ExpectedCount) divided by the number of nonoutlier persons in the initial population (NonOutlierPersonCount), multiplied by 1,000 within each age group and totals. Calculated by IDSS as the ExpectedRate.

Reporting: Variance among nonoutlier persons

The variance (*Risk Adjustment Calculation*, PUCD, step 5) within each age group, reported as the CountVariance.

Calculated: O/E ratio

The number of observed discharges among nonoutlier persons (ObservedCount) divided by the number of expected discharges among nonoutlier persons (ExpectedCount) for each age group and totals. Calculated by IDSS as the OE.

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table AHU-1: Data Elements for Acute Hospital Utilization

Metric	Age	Data Element	Reporting Instructions
AcuteHospitalUtilization	18-21	NonOutlierPersonCount	For each Stratification
	22-34	OutlierPersonCount	For each Stratification
	35-44	PersonCount	NonOutlierPersonCount + OutlierPersonCount
	18-44	OutlierRate	OutlierPersonCount / PersonCount (Per mille)
	45-54	ObservedCount	For each Stratification
	55-64	ObservedRate	1000 * ObservedCount / NonOutlierPersonCount
	18-64	ExpectedCount	For each Stratification
		ExpectedRate	1000 * ExpectedCount / NonOutlierPersonCount
		CountVariance	For each Stratification
		OE	ObservedCount / ExpectedCount

Table AHU-2/3: Data Elements for Acute Hospital Utilization

Metric	Age	Data Element	Reporting Instructions
AcuteHospitalUtilization	18-44	NonOutlierPersonCount	For each Stratification
	45-54	OutlierPersonCount	For each Stratification
	55-64	PersonCount	NonOutlierPersonCount + OutlierPersonCount
	18-64	OutlierRate	OutlierPersonCount / PersonCount (Per mille)
	65-74	ObservedCount	For each Stratification
	75-84	ObservedRate	1000 * ObservedCount / NonOutlierPersonCount

	Metric	Age	Data Element	Reporting Instructions
		85+	ExpectedCount	For each Stratification
		65+	ExpectedRate	1000 * ExpectedCount / NonOutlierPersonCount
	Total		CountVariance	For each Stratification
			OE	ObservedCount / ExpectedCount
Rules for Allowable Adjustments	Copyright and use: The “Rules for Allowable Adjustments of HEDIS” (the “Rules”) describe how NCQA’s HEDIS measure specifications can be adjusted for other populations, if applicable. The Rules, reviewed and approved by NCQA measure experts, provide for expanded use of HEDIS measures without changing their clinical intent. Adjusted HEDIS measures may not be used for HEDIS health plan reporting. The measures under the Risk Adjusted Utilization domain allow two types of <i>Rules for Allowable Adjustments</i> sections: 1. <i>Rules for Allowable Adjustments for Risk-Adjusted Measurement.</i> This section must be followed for adjustments when calculating the full measure specifications, which includes all risk adjusted rates (expected rates, risk adjustment, O/E) and calculation components (count of index stays, observed events). 2. <i>Rules for Allowable Adjustments for Observed Measurement (rates without risk adjustment).</i> This section must be followed when adjusting the calculation of observed events only. When applying these adjustments, organizations must not include risk adjustment logic. The intent of including the two different types of Rules is to allow organizations to adjust measures without compromising the measures’ validity. Risk adjustment is based on statistical prediction models that are specifically calibrated for each measure. The following are the Rules for Allowable Adjustments for Risk-Adjusted Measurement of the Acute Hospital Utilization measure (observed discharges, expected discharges, risk adjustment determination, risk adjustment weighting, O/E, variance). ADJUSTMENTS ALLOWED • <i>Benefits.</i> Organizations are not required to use a benefit. • <i>Telehealth.</i> Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth. ADJUSTMENTS ALLOWED WITH LIMITS • <i>Other.</i> Organizations may only adjust the initial population criteria to focus on an area of interest defined by gender, sociodemographic characteristics or geographical region. NCQA recommends evaluating risk model performance			

and validity within adjusted populations. Organizations may not adjust for a clinical subpopulation (e.g., persons with a diabetes diagnosis).

- *Measurement period adjustments.* Organizations may only change the measurement period by 1 year.
- *Initial population.* Organizations may include denied claims to calculate the initial population. The logic may not be changed.
- *Discharges.* Organizations may include denied claims to calculate observed events. Only events or diagnoses that contain (or map to) codes in value sets may be used to identify visits. The value sets and logic may not be changed.
- *Outlier.* Organizations may include denied claims to calculate these events. Organizations may not adjust the outlier logic.
- *Risk adjustment determination, risk adjustment weighting, expected count of discharges, variance.* Organizations may include denied claims to calculate these events. Risk adjustment determinations, weighting and calculations of expected events logic may not be changed.

ADJUSTMENTS NOT ALLOWED

- *Product lines.* Organizations may not adjust product lines.
- *Attribution.* Organizations are required to use enrollment criteria.
- *Ages.* The age determination dates may not be changed.
- *Supplemental data.* Supplemental data may not be used to identify initial population (with the exception of the hospice exclusion) or any events.
- *Exclusions.* The hospice exclusion must be applied. Logic may not be changed.

The following are the Rules for Allowable Adjustments for Observed Measurement of the Acute Hospital Utilization measure observed events (observed discharges).

ADJUSTMENTS ALLOWED

- *Product lines.* When adjusting this measure to assess for observed events only, organizations are not required to use product line criteria; product lines may be combined, and all (or no) product line criteria may be used.
- *Ages.* The observed event age range may be expanded. Age determination dates may be changed (e.g., select, “age as of June 30”).
- *Attribution.* Organizations are not required to use enrollment criteria.
- *Benefits.* Organizations are not required to use a benefit.
- *Other.* Organizations may use additional initial population criteria to focus on a population of interest such as gender, race and ethnicity, socioeconomic, sociodemographic characteristics, geographic region or another characteristic.
- *Measurement period adjustments.* Organizations may adjust the measurement period.
- *Exclusions.* Hospice exclusion is not required.

- *Outlier.* Organizations may adjust the outlier logic. The outlier logic is not required to be applied. The outlier thresholds may be expanded or reduced. Denied claims may be used to calculate these events.
- *Telehealth.* Services/events that allow the use of synchronous telehealth visits, telephone visits and asynchronous telehealth (e-visits, virtual check-ins) may be stratified to identify services performed via telehealth. This adjustment is not allowed for events/diagnoses, numerators and exclusions that do not allow the use of telehealth.
- *Supplemental data.* Supplemental data may be used to identify initial population and all events.

ADJUSTMENTS ALLOWED WITH LIMITS

- *Discharges.* Organizations may include denied claims to calculate observed events. Only events or diagnoses that contain (or map to) codes in value sets may be used to identify visits. The value sets and logic may not be changed.