Massachusetts Division of Insurance's
Health Maintenance Organization Guidelines for
Reporting Membership & Utilization Statistics ("Data Guidelines")

Version 5.0
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TABLE OF CONTENTS

I.	Introduction	3
II	Timing	4
III.	General	5 – 6
IV.	Membership	7
V.	Member Months	8
VI.	Inpatient Non-Behavioral Health Utilization	9
VII.	Inpatient Behavioral Health Utilization	10 – 11
VIII.	Intermediate Care Behavioral Health Utilization	12 – 13
IX.	Outpatient Non-Behavioral Health Utilization	14 – 15
X.	Outpatient Behavioral Health Utilization	16 – 19
XI.	Attachments	20

I. INTRODUCTION

According to the provisions of 211 CMR 43.05(2), each Health Maintenance Organization ("HMO") shall file quarterly reports with the Massachusetts Division of Insurance ("Division") within 45 days of the close of each calendar quarter in the format specified by the National Association of Insurance Commissioners ("NAIC") or as otherwise specified by the Commissioner. The official NAIC "Statement Blanks for HMOs", commonly referred to as "Orange Blanks," and herein called "NAIC reports," include financial as well as statistical reports to be completed by each state's HMOs.

Up through 2002, HMOs submitted detailed data worksheets created by the Division to explain the membership and utilization reported as part of the NAIC's Exhibit of Premiums, Enrollment and Utilization, a table within the NAIC reports (see example attached). As of 2003, HMOs continue to submit their quarterly NAIC reports within 45 days of the close of the calendar quarters, but only submit with those reports the Division's detailed data worksheets on membership statistics (as attached). Separate from the quarterly NAIC reports and Division's membership data worksheets, HMOs shall submit semi-annually to the Division supplemental worksheets created by the Division (as attached) that provide detail regarding utilization statistics. These Data Guidelines are intended to define the data HMOs should submit to the Division to supplement what is reported in the NAIC reports. These Data Guidelines are not tied to the NAIC reports, and the Division will not reconcile statistics reported pursuant to these Data Guidelines with what is reported within the NAIC reports.

The Division created the attached data worksheets in Microsoft Excel® format to be used by HMOs when developing the following reports:

Quarterly Membership Report for Closed and Insured Preferred Provider Network Plans:

1. Quarterly Membership

Supplemental Utilization Report - Closed and Insured Preferred Provider Network Plans:

2. Inpatient Non-Behavioral Health Utilization Data
3. Inpatient Behavioral Health Utilization Data – Closed Network Plans only
4. Inpatient Behavioral Health Utilization Data – Preferred Provider Network Plans only
5. Intermediate Care Behavioral Health Utilization Data – Closed Network Plans only
6. Intermediate Care Behavioral Health Utilization Data – Preferred Provider Network Plans only
7. Outpatient Non-Behavioral Health Utilization Data
8. Outpatient Behavioral Health Utilization Data – Closed Network Plans only
9. Outpatient Behavioral Health Utilization Data – Preferred Provider Network Plans only
10. Member Months – Closed Network Plans only
11. Member Months – Preferred Provider Network Plans only

II. TIMING

The Division requests that HMOs submit membership and utilization statistics based on the following timelines:

REPORT TYPE	REPORTING PERIOD	INCURRED DATES	PAID-THROUGH DATE *	SUBMISSION DUE DATE
NAIC Report & Quarterly Membership	First Quarter	N/A (no utilization statistics)	N/A (no utilization statistics)	May 15th
NAIC Report & Quarterly Membership	Second Quarter	N/A (no utilization statistics)	N/A (no utilization statistics)	August 15th
Supplemental Utilization	Mid-Year	January – June (six months)	September 30th	November 15th
NAIC Report & Quarterly Membership	Third Quarter	N/A (no utilization statistics)	N/A (no utilization statistics)	November 15th
NAIC Report & Quarterly Membership	Fourth Quarter	N/A (no utilization statistics)	N/A (no utilization statistics)	March 1st
Supplemental Utilization	Year-End	January - December (twelve months)	March 31st	May 15th

*** This is the date each HMO should run reports necessary to obtain all utilization statistics.**

III. GENERAL

In order to complete reports according to the NAIC reporting guidelines, all membership and utilization statistics should be reported in **which the risk of financial loss has been transferred to the HMO**. Since the Division is not responsible for the activities of self-funded groups, **HMOs must ensure that these reports do not include statistics when the HMO is performing the duties of a third party administrator (TPA) or acting in a similar capacity for self-funded groups.**

HMOs must report statistics for members of all insured products regardless of the member's state of residence. Membership and utilization statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.,* where the member's employer or health care provider is located). For members enrolled in a so-called "dual certificate option" plan (POS), statistics should be included under Insured Preferred Provider Network Plans on the data worksheets.

Please note that the following definitions are intended to clarify definitions already part of NAIC guidelines and to use definitions in common usage, including what is defined in the most recent version of the Health Plan Employer and Data Information Set ("HEDIS®") technical specifications. HEDIS® is a registered trademark of the National Committee for Quality Assurance ("NCQA"). As used within the Data Guidelines, the "most recent version of HEDIS®" refers to the version applicable at the time the mid-year Supplemental Utilization report is filed; the same version of HEDIS used for the mid-year report should be used for the year-end report.

In accordance with NAIC guidelines, statistics should be reported for each of the following categories:

1. **Group** – members enrolled with the HMO through an entity (*e.g.,* employer, association, or trust) paying premiums to the HMO to cover eligible members of the entity. This category includes the following types of group members:

    <u>POS</u> – members enrolled in so-called "dual certificate option" plans whereby a member receives two certificates and is covered by both the HMO, with a "closed network," and an indemnity carrier, with an "open network."

    <u>GIC</u> – employees of the Massachusetts state government enrolled through the Group Insurance Commission.

    <u>Federal</u> – employees of the federal government.

    <u>COBRA</u> – members who receive their health coverage from the HMO pursuant to continuation of coverage protections guaranteed by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and members who receive their health coverage pursuant to M.G.L. c. 176J § 9 for groups with 2 – 19 eligible employees.

    <u>Merged Market</u> – members enrolled in those merged small group/individual products (pursuant to Chapter 58 of the Acts of 2006) who belong to an entity (*e.g.,* employer, association, or trust) paying premiums to the HMO to cover eligible members of the entity.

III. GENERAL (continued)

Commonwealth Choice – members enrolled in the Commonwealth Choice contributory plan.

2. Medicare Advantage – members enrolled in a Medicare Advantage contract with the Centers for Medicare and Medicaid Services ("CMS").

3. Other Medicare – members enrolled in other Medicare plans including, for example, so-called Medicare Wrap-Around policies.

4. Medicaid – members with HMO health coverage in which reimbursement is provided pursuant to Title XIX of the Federal Social Security Act.

5. Individual – members who do not belong to a group and who directly contract with the HMO for coverage. Statistic includes those merged small group/individual product (pursuant to Chapter 58 of the Acts of 2006) members who enroll as individuals, and do not belong to a group. Statistic also includes Commonwealth Care members, members enrolled in the Commonwealth Choice non-contributory plan, closed guaranteed issue health plan members, and closed nongroup health plan members. Statistic may include subscriber's formerly dependent divorced spouses following subscriber's remarriage. Statistic does not include (a) individual conversion policy members (included in the Other category); (b) COBRA members (included in the Group category); or (c) self-employed small group members (included in the Group category).

6. Other – members whose group coverage and COBRA coverage have expired and who have converted to an individual (conversion) policy.

Relative to the information reported on the Division's worksheets, statistics should be separated as follows:

HMO Closed Network Plans

1. Plans where a member only has the option to receive services from a contracted provider.

HMO Insured Preferred Provider Network Plans

1. "Open network" plans where a member has the option of receiving services from either a contracted "in-network" provider or a non-contracted "out-of-network" provider or
2. For purposes of these Data Guidelines only, so-called "dual certificate option" plans (POS) where a member receives two certificates and is covered by both the HMO and indemnity carrier.

If you have questions regarding which of your insured plans fall into which category, please contact the Division.

IV. MEMBERSHIP (see worksheet "Quarterly Membership ")

Membership will be reported based upon a member's primary residence only, and not on any other factor (*e.g.*, where a member's employer or health care provider is located). The membership statistics will reflect information for the following categories:

1. Members residing in Massachusetts will be reported based on their county of residence and
2. Members residing outside Massachusetts will be in "Other States" Category.

For members enrolled in a so-called "dual certificate option" plan (POS), membership statistics should be included under Insured Preferred Provider Network Plans on the data worksheets.

When developing the statistics, the following definitions are to be used:

Health Maintenance Organization (HMO) - an entity or line of business licensed according to the provisions of Massachusetts General Laws c. 176G.

Member - HMO subscriber or covered dependent of a subscriber (including divorced spouses covered under the HMO and newborns covered under the HMO) for whom the HMO has accepted the risk of financing necessary health services. A member is first counted as of his/her effective date of coverage. **When a member is "dually enrolled" (*e.g.,* covered by the HMO under the subscriber's and spouse's plans), the HMO should count this as one membership**. Membership should be reported by county according to the zip code of the member's primary residence listed on the member record (or subscriber record, if dependent's address is not available). If the member's primary residence is outside Massachusetts, then the member should be included in the "Other States" category.

Include:

3. All persons who receive health coverage from the reporting HMO regardless of where the member's employer or health care provider is located.
4. All group, Medicare + Choice, other Medicare, Medicaid, individual, and "conversion" members.
5. Members living outside of Massachusetts.

Exclude:

6. Individuals not enrolled in an insured product *i.e.* self-funded plans for which the licensed HMO only acts as a third party administrator (TPA).
7. Fee-for-service patients seen at HMO-owned health centers.

Members at End Of Quarter - members enrolled in the HMO as of the close of business **on the last day of the calendar quarter.** A member is first counted as of his/her effective date of coverage. Dual enrollments should only be counted once.

V. MEMBER MONTHS (see worksheet "Member Months")

Cumulative Member Months - Number of months of coverage **since the beginning of calendar year for which the HMO has recognized membership**. Figure should include adjustments to prior quarter member months to reflect retroactively reported additions or terminations to membership.

Example: A membership becomes effective on February 1, 2003. For purposes of the first quarter 2003 report, the report will include two member months (February and March) to represent that individual enrollee.

VI. INPATIENT NON-BEHAVIORAL HEALTH UTILIZATION
(see worksheet "Inpatient Non-Behavioral Health Utilization Data ")

Inpatient non-behavioral health utilization should be reported for the entire HMO, whether provided or arranged by the HMO or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**. **For members enrolled in a so-called "dual certificate option" plan (POS), all utilization statistics should be included under Insured Preferred Provider Network Plans on the data worksheets whether services were paid under the HMO or indemnity carrier certificate**.

For reporting inpatient non-behavioral health utilization, include all paid claims incurred during the reporting period with "paid through dates" consistent with the dates noted in Section II above. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the HMO has made payment to the provider of service.

Include: utilization of HMO members for which HMO is at least partially financially responsible (*e.g.* is the secondary or tertiary payer) regardless of where the inpatient care occurred.

Exclude: utilization of non-HMO members and **all HMO member inpatient utilization that falls under inpatient behavioral health and intermediate care behavioral health that is to be reported separately as described below**.

Acute Care - non-behavioral health care in a hospital licensed as an acute care facility by the state in which the facility is located.

Med./Surg. - medical and surgical care as defined in the most recent version of HEDIS®. Excludes well newborn days coincident with a maternity stay.

Maternity - as defined in the most recent version of HEDIS®.

Non-Acute - non-behavioral health care in an inpatient facility or ward of a facility licensed by the state in which the facility is located but not as an acute facility. This includes, but is not limited to, the following: skilled nursing home, long-term care; intermediate care; rehabilitation; and hospice.

Discharge - formal release of patient from a facility for any reason, including death.

Discharge Day - inpatient day associated with a discharge that occurred during the reporting period. All associated paid claim days are counted, even if those days occurred prior to the beginning of the reporting period.

VII. INPATIENT BEHAVIORAL HEALTH UTILIZATION

(see worksheets "Inpatient Behavioral Health Utilization Data – Closed Network Plans" and "Inpatient Behavioral Health Utilization Data – Insured Preferred Provider Network Plans")

Inpatient behavioral health utilization should be reported for the entire HMO, whether provided or arranged by the HMO or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**. **For members enrolled in a so-called "dual certificate option" plan (POS), all utilization statistics should be included under Insured Preferred Provider Network Plans on the data worksheets whether services were paid under the HMO or indemnity carrier certificate**.

For reporting inpatient behavioral health utilization, include all paid claims incurred during the reporting period with "paid through dates" consistent with the dates noted in Section II above. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the HMO has made payment to the provider of service.

Include: utilization of HMO members for which HMO is at least partially financially responsible (*e.g.* is the secondary or tertiary payer) regardless of where the inpatient care occurred.

Exclude: utilization of non-HMO members and **all HMO member inpatient utilization that falls under inpatient non-behavioral health and intermediate care behavioral health that is to be reported separately as described elsewhere in this document.**

Discharge - formal release of patient from a facility for any reason, including death.

Discharge Day - inpatient day associated with a discharge that occurred during the reporting period. All associated paid claim days are counted, even if those days occurred prior to the beginning of the reporting period.

Inpatient behavioral health utilization should be reported based on the age at time of admission according to the following age ranges as indicated on the attached data worksheets: 0-5; 6-12; 13-18; 19-25; 26-64; and 65+. All inpatient behavioral health care is to be reported according to the categories defined below:

Major Depression: ((DRGs 876 or between 880 and 887) **and** (Primary ICD-9 diagnosis codes between 296.2 and 296.36)).

Attention Deficit Hyperactivity Disorder (ADHD): ((DRGs 876 or between 880 and 887) **and** (Primary ICD-9 diagnosis codes between 314 and 314.9)).

Eating Disorders: ((DRGs 876 or between 880 and 887) **and** (Primary ICD-9 diagnosis codes 307.1 or between 307.5 and 307.59)).

VII. INPATIENT BEHAVIORAL HEALTH UTILIZATION (continued)

Chemical Dependency:	((DRGs between 894 and 897 or between 917 and 918) **and** (Primary ICD-9 diagnosis codes between 291 and 292.9 or between 303 and 305.93) **or** (Primary ICD-9 diagnosis codes between 960 and 979 and Secondary ICD-9 diagnosis codes between 291 and 292.9 or between 303 and 305.93)).
Other Mental Health (excluding all conditions noted above):	((DRGs 876 or between 880 and 887) **and** (Primary ICD-9 diagnosis codes between 290.0 and 316. and not between 291 and 292.9 and not between 296.2 and 296.36 and not between 303 and 305.93 and not like 307.1 and not between 307.5 and 307.59 and not between 314 and 314.9)).

VIII. INTERMEDIATE CARE BEHAVIORAL HEALTH UTILIZATION
(see worksheets "Intermediate Care Behavioral Health Utilization Data – Closed Network Plans" and "Intermediate Care Behavioral Health Utilization Data – Insured Preferred Provider Network Plans")

Intermediate care behavioral health utilization should be reported for the entire HMO, whether provided or arranged by the HMO or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**. **For members enrolled in a so-called "dual certificate option" plan (POS), all utilization statistics should be included under Insured Preferred Provider Network Plans on the data worksheets whether services were paid under the HMO or indemnity carrier certificate**.

For reporting intermediate care behavioral health utilization, include all paid claims incurred during the reporting period with "paid through dates" consistent with the dates noted in Section II above. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the HMO has made payment to the provider of service.

Include: utilization of HMO members for which HMO is at least partially financially responsible (*e.g.,* is the secondary or tertiary payer) regardless of where the intermediate care services occurred.

Exclude: utilization of non-HMO members; day treatment that is long-term custodial maintenance ("club house" models) and **all HMO member utilization that falls under inpatient behavioral health and outpatient behavioral health that is to be reported separately as described elsewhere in this document**.

Discharge - formal release of patient from a facility for any reason, including death.

Discharge Day - inpatient day associated with a discharge that occurred during the reporting period. All associated paid claim days are counted, even if those days occurred prior to the beginning of the reporting period.

Encounters – face-to-face visit with a provider who utilizes independent judgment in providing intermediate care behavioral health to patients. Each face-to-face visit with a provider is recorded as an encounter except in cases where the patient sees multiple providers in the same visit, which should be recorded as one encounter.

Intermediate care behavioral health utilization should be reported based on the age on date of service according to the following age ranges: 0-5; 6-12; 13-18; 19-25; 26-64; and 65+ and grouped by the following categories: Major Depression, Attention Deficit Hyperactivity Disorder (ADHD), Eating Disorders, Chemical Dependency, and Other Mental Health as indicated on the attached data worksheets.

VIII. INTERMEDIATE CARE BEHAVIORAL HEALTH UTILIZATION (continued)

Statistics should be compiled based on the HMO's internal data codes used for its insured benefit plans and should include any of the following services:

24-Hour/Overnight Intermediate Care Behavioral Health Services:
(reported as Discharges and Discharge Days)

1. Acute Treatment Services for Substance Abuse (formerly known as Level III Community Based Detoxification);
2. Acute Residential Treatment;
3. Crisis Stabilization;
4. Observation/Holding Beds;
5. Dual Diagnosis (Mental Health and Substance Abuse) Acute Residential Treatment; and
6. Clinical Support Services-Substance Abuse (formerly known as Residential Substance Abuse Treatment).

Community Based Intermediate Care Behavioral Health Services:
(reported as Encounters)

1. Partial Hospitalization;
2. Day Treatment;
3. Family Stabilization Services;
4. Intensive Outpatient Programs;
5. Community Support Programs; and
6. Structured Outpatient Addiction Programs.

IX. OUTPATIENT NON-BEHAVIORAL HEALTH UTILIZATION
(see worksheet "Outpatient Non-Behavioral Health Utilization Data ")

Outpatient non-behavioral health utilization should be reported for the entire HMO, whether provided or arranged by the HMO or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**. **For members enrolled in a so-called "dual certificate option" plan (POS), all utilization statistics should be included under Insured Preferred Provider Network Plans on the data worksheets whether services were paid under the HMO or indemnity carrier certificate**.

For reporting outpatient non-behavioral health utilization, include all paid claims incurred during the reporting period with "paid through dates" consistent with the dates noted in Section II above. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the HMO has made payment to the provider of service.

Include: all primary care and referral encounters for HMO members whether at in-plan health centers, in-network doctor offices, out-of-network locations, out-of-area claims or capitated provider visits; statistic should also include all visits to providers regardless of location at which treatment took place.

Exclude: utilization of non-HMO members; all inpatient care, lab/x-ray tests, and pharmacy transactions; **and all HMO member outpatient utilization that falls under outpatient behavioral health or intermediate care behavioral health that is to be reported separately as described elsewhere in this document**.

Office Visit – non-behavioral health care encounters that are not emergency room as defined below which are included in other groupings. Include office-based surgical procedures.

Ambulatory Surgery – as defined in the most recent version of HEDIS®.

Observation Day – as defined in the most recent version of HEDIS®.

Emergency Room – as defined in the most recent version of HEDIS®.

Physicians – Medical Doctors and Doctors of Osteopathy providing other than behavioral health services.

Non-physicians – all other health professionals noted in the encounter section that provide health services to members other than behavioral health services.

IX. OUTPATIENT NON-BEHAVIORAL HEALTH UTILIZATION (continued)

Encounter – face-to-face visit with a provider who utilizes independent judgment in providing medical care to patients whether in a provider office, an inpatient facility, or at a patient's home. Each face-to-face-visit is recorded as an encounter except in cases where the patient sees a nurse practitioner (or similar clinician) and a physician in the same visit, which should be recorded as one encounter under the "physician" category. This statistic may be based on the most recent version of HEDIS® defined CPT™ codes for the following provider types:

Include visits with: physicians, podiatrists, optometrists, audiologists, speech language pathologists, chiropractors, dentists, physician assistants, nurse practitioners, certified nurse midwives, therapists (speech, physical, occupational, rehabilitative), nutritionists, health educators, and Christian Science practitioners.

Exclude visits with: registered nurses, nurse aides, x-ray technicians, lab assistants, pharmacists, and medical supply vendors, **and all behavioral health professionals that are to be reported separately as described below**.

X. OUTPATIENT BEHAVIORAL HEALTH UTILIZATION
(see worksheet "Outpatient Behavioral Health Utilization Data")

Outpatient behavioral health utilization should be reported for the entire HMO, whether provided or arranged by the HMO or any delegated entity or contracting network. **Statistics should be reported based upon a member's primary residence only, and not on any other factor (*e.g.* where the member's employer or health care provider is located)**. **For members enrolled in a so-called "dual certificate option" plan (POS), all utilization statistics should be included under Insured Preferred Provider Network Plans on the data worksheets whether services were paid under the HMO or indemnity carrier certificate**.

For reporting outpatient behavioral health utilization, include all paid claims incurred during the reporting period with "paid through dates," consistent with the dates noted in Section II above. For the purpose of these Data Guidelines, "paid claims" mean any claim in which the HMO has made payment to the provider of service.

Include: all behavioral health treatment for HMO members whether at in-plan health centers, in-network provider offices, out-of-network locations, out-of-area claims or capitated provider visits; statistic should also include all visits to providers regardless of location at which treatment took place.

Exclude: utilization of non-HMO members; all inpatient care, lab/x-ray tests, and pharmacy transactions; and **all HMO member outpatient utilization that falls under outpatient non-behavioral health and intermediate care behavioral health that is reported separately as described above**.

Physicians – Medical Doctors or Doctors of Osteopathy providing behavioral health services.

Non-physicians – the following licensed or otherwise certified health professionals who provide behavioral health services: psychologists; psychotherapists; independent clinical social workers; mental health counselors; nurse mental health clinical specialists; alcohol and drug counselors; marriage and family therapists; advanced practice registered nurses; registered nurse clinical specialists; nurse practitioners; and psychiatric clinical nurse specialists.

Encounters – face-to-face visit with a physician or non-physician who provides behavioral health services who utilizes independent judgment in providing behavioral health care to patients whether in a provider office, inpatient facility, or at a patient's home. Each face-to-face visit with a behavioral health provider is recorded as an encounter except in cases where the patient sees a physician and non-physician in the same visit, which should be recorded as one encounter under the "physician" category. Outpatient behavioral health encounters should be reported based on the age on date of service according to the following age ranges as indicated on the attached data worksheets: 0-5; 6-12; 13-18; 19-25; 26-64; and 65+.

X. OUTPATIENT BEHAVIORAL HEALTH UTILIZATION (continued)

All outpatient behavioral health care is to be reported according to the categories defined below. Please note that a behavioral health professional must perform all services with an Evaluation and Management procedure code (CPT beginning with "99") in order to be included:

Major Depression:

((Between 90801 and 90802 or between 90804 and 90829 or between 90845 and 90849 or like 90853 or like 90857 or like 90862 or between 90870 and 90871 or like 96100 or like 96117 or between 99201 and 99205 or between 99211 and 99215 or between 99217 and 99220 or between 99241 and 99245 or between 99341 and 99345 or between 99347 and 99350 or between 99381 and 99387 or between 99391 and 99397 or between 99401 and 99404 or between 99411 and 99412) **and** (Primary ICD-9 Diagnosis codes between 296.2 and 296.36) **and** (Site of Service Codes 11 or 22 or 23 or 53 or 71 or 72)).
OR
((UB-92 Revenue Codes between 450 and 452 or like 456 or like 459 or between 900 and 903 or between 909 and 911 or between 914 and 916 or between 918 and 919) **and** (Type of Bill Codes 13X or 43X) **and** (Primary ICD-9 Diagnosis codes between 296.2 and 296.36)).

Attention Deficit Hyperactivity Disorder (ADHD):

((Between 90801 and 90802 or between 90804 and 90829 or between 90845 and 90849 or like 90853 or like 90857 or like 90862 or between 90870 and 90871 or like 96100 or like 96117 or between 99201 and 99205 or between 99211 and 99215 or between 99217 and 99220 or between 99241 and 99245 or between 99341 and 99345 or between 99347 and 99350 or between 99381 and 99387 or between 99391 and 99397 or between 99401 and 99404 or between 99411 and 99412) **and** (Primary ICD-9 Diagnosis codes between 314 and 314.9) **and** (Site of Service Codes 11 or 22 or 23 or 53 or 71 or 72)).
OR
((UB-92 Revenue Codes between 450 and 452 or like 456 or like 459 or between 900 and 903 or between 909 and 911 or between 914 and 916 or between 918 and 919) **and** (Type of Bill Codes 13X or 43X) **and** (Primary ICD-9 Diagnosis codes between 314 and 314.9)).

X. OUTPATIENT BEHAVIORAL HEALTH UTILIZATION (continued)

Eating Disorders:	((Between 90801 and 90802 or between 90804 and 90829 or between 90845 and 90849 or like 90853 or like 90857 or like 90862 or between 90870 and 90871 or like 96100 or like 96117 or between 99201 and 99205 or between 99211 and 99215 or between 99217 and 99220 or between 99241 and 99245 or between 99341 and 99345 or between 99347 and 99350 or between 99381 and 99387 or between 99391 and 99397 or between 99401 and 99404 or between 99411 and 99412) **and** (Primary ICD-9 Diagnosis codes 307.1 or between 307.5 and 307.59) **and** (Site of Service Codes 11 or 22 or 23 or 53 or 71 or 72)). **OR** ((UB-92 Revenue Codes between 450 and 452 or like 456 or like 459 or between 900 and 903 or between 909 and 911 or between 914 and 916 or between 918 and 919) **and** (Type of Bill Codes 13X or 43X) **and** (Primary ICD-9 Diagnosis codes 307.1 or between 307.5 and 307.59)).
Chemical Dependency:	((Between 90801 and 90802 or between 90804 and 90829 or between 90845 and 90849 or like 90853 or like 90857 or like 90862 or between 90870 and 90871 or like 96100 or like 96117 or between 99201 and 99205 or between 99211 and 99215 or between 99217 and 99220 or between 99241 and 99245 or between 99341 and 99345 or between 99347 and 99350 or between 99381 and 99387 or between 99391 and 99397 or between 99401 and 99404 or between 99411 and 99412) **and** (Primary ICD-9 Diagnosis codes between 291 and 292.9 or between 303 and 305.93) **and** (Site of Service Codes 11 or 22 or 23 or 53 or 71 or 72)). **OR** ((Between 90801 and 90802 or between 90804 and 90829 or between 90845 and 90849 or like 90853 or like 90857 or like 90862 or between 90870 and 90871 or like 96100 or like 96117 or between 99201 and 99205 or between 99211 and 99215 or between 99217 and 99220 or between 99241 and 99245 or between 99341 and 99345 or between 99347 and 99350 or between 99381 and 99387 or between 99391 and 99397 or between 99401 and 99404 or between 99411 and 99412) **and** (Primary ICD-9 Diagnosis codes between 960 and 979 and Secondary ICD-9 Diagnosis codes between 291 and 292.9 or between 303 and 305.93) **and** (Site of Service Codes 11 or 22 or 23 or 53 or 71 or 72)). **OR**

Chemical Dependency (continued):

((UB-92 Revenue Codes 944 or 945) **and** (Type of Bill Codes 13X or 43X) **and** (Primary ICD-9 Diagnosis codes between 291 and 292.9 or between 303 and 305.93)).
OR
((UB-92 Revenue Codes 944 or 945) **and** (Type of Bill Codes 13X or 43X) **and** (Primary ICD-9 Diagnosis codes between 960 and 979 and Secondary ICD-9 Diagnosis codes between 291 and 292.9 or between 303 and 305.93)).

Other Mental Health (excluding all conditions noted above):

((Between 90801 and 90802 or between 90804 and 90829 or between 90845 and 90849 or like 90853 or like 90857 or like 90862 or between 90870 and 90871 or like 96100 or like 96117 or between 99201 and 99205 or between 99211 and 99215 or between 99217 and 99220 or between 99241 and 99245 or between 99341 and 99345 or between 99347 and 99350 or between 99381 and 99387 or between 99391 and 99397 or between 99401 and 99404 or between 99411 and 99412) **and** (Primary ICD-9 Diagnosis codes between 290 and 316 and not between 291 and 292.9 and not between 296.2 and 296.36 and not between 303 and 305.93 and not like 307.1 and not between 307.5 and 307.59 and not between 314 and 314.9) **and** (Site of Service Codes 11 or 22 or 23 or 53 or 71 or 72)).
OR
((UB-92 Revenue Codes between 450 and 452 or like 456 or like 459 or between 900 and 903 or between 909 and 911 or between 914 and 916 or between 918 and 919) **and** (Type of Bill Codes 13X or 43X) **and** (Primary ICD-9 Diagnosis codes between 290 and 316 and not between 291 and 292.9 and not between 296.2 and 296.36 and not between 303 and 305.93 and not like 307.1 and not between 307.5 and 307.59 and not between 314 and 314.9)).

XI. ATTACHMENTS

1. Example of NAIC table: Exhibit of Premiums, Enrollment and Utilization.

2. Data worksheets:

   1. Quarterly Membership
   2. Inpatient Non-Behavioral Health Utilization Data
   3. Inpatient Behavioral Health Utilization Data – Closed Network Plans only
   4. Inpatient Behavioral Health Utilization Data – Preferred Provider Network Plans only
   5. Intermediate Care Behavioral Health Utilization Data – Closed Network Plans only
   6. Intermediate Care Behavioral Health Utilization Data – Preferred Provider Network Plans only
   7. Outpatient Non-Behavioral Health Utilization Data
   8. Outpatient Behavioral Health Utilization Data – Closed Network Plans only
   9. Outpatient Behavioral Health Utilization Data – Preferred Provider Network Plans only
   10. Member Months – Closed Network Plans only
   11. Member Months – Preferred Provider Network Plans only