Table 6A: Selected Diagnoses and Services Rendered

PURPOSE:

Table 6A is part of the clinical profile that reports on two separate sets of data: selected diagnoses and selected services rendered. It is designed to provide information on diagnoses and services using data maintained for billing purposes, lab reports, and/or electronic health record (EHR)/Health Information Technology (HIT) data.

CHANGES:

- Applicable ICD-10-CM Codes, Value Set Object Identifiers (OID), CPT-4/I/PLA, and HCPCS Codes have been updated for 2023.
- 2023 Table 6A code changes will be available for download.
- Codes are updated as of April 2023.
- Codes may be updated later in the year to capture critical updates made after this date.
- A new line (26e) has been added to report childhood developmental screenings and evaluation services.
- In addition to submitting this table as described below within the EHBs, health centers may voluntarily submit de-identified patient-level report data using Health Level Seven (HL7®) Fast Healthcare Interoperability Resources (FHIR®) R4 standards for this table.

KEY TERMS:

VISIT: For a service to be counted as a visit in Column A on Table 6A, it must either be delivered at the time of a visit that was counted on Table 5 (include clinic visits — Column B and virtual visits — Column b2) or as a result of an order from a prior visit (such as a vaccination ordered for 40 days later during a well-child visit).

PATIENTS: Individuals who have one or more face-to-face or virtual UDS-countable visits during the calendar year.

HOW DATA ARE USED:

To calculate:

- *The average visits per patient* per year for a particular condition and/or service — divide Column B by Column A (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 penetration rate for routine preventative services* (e.g., children who received well child visits).
- *Proportion of patients receiving tests or services of a selected age group* (e.g., percent of women who receive contraceptive services of women age 15-44; percent of women receiving Pap tests of women age 23-64).

CROSS TABLE CONSIDERATIONS:

- Visits and patients reported in any cell of the grant-specific tables cannot exceed the number reported in the same cell of any table on the Universal Report.
- **Tables 6A, Table 5 and Addendum**: Table 6A activity reported for substance use disorder and mental health treatment are compared to the Table 5 addendum and the main part of Table 5 mental health and substance use lines.
- **Tables 6A and 7:** Table 6A is NOT the same as Table 7. Patients reported with diabetes or hypertension on Table 6A may not satisfy the additional criteria that must be met for inclusion on Table 7. Similarly, some patients counted on Table 7 may not have had a reported visit on Table 6A.

For more detailed information see UDS Reporting Instructions for CY 2023 Health Center Data, UDS Manual, pages 77 – 88.

Table 6A: Selected Diagnoses and Services Rendered

- **Table 6A and 6B:** Tobacco use disorder on Table 6A (Line 19a) is NOT the same as patients identified as tobacco users on Table 6B (Line 14a) because Table 6B has additional inclusion criteria.

TABLE TIPS:

Table 6A is completed for the Universal Report and the grant-specific reports (if applicable).

Please note: Clinic and Virtual visits, as reported on Table 5 are both included everywhere that visits are referred to on this page.

PATIENTS AND VISITS:

- **Column A:** Total visits with a specific diagnosis (Lines 1–20f) or service (Lines 21–34) indicated.
- **Column B:** Unduplicated number of patients with diagnosis or having received service.
- If a patient is seen for multiple diagnoses in one visit, they must be reported once on each appropriate diagnosis line. Similarly, if a patient receives multiple services in one visit, they must be counted once on each appropriate service line.

SELECTED DIAGNOSES (LINES 1–20f):

- 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 once on Line 11).
- 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, the shot is counted because it is considered to be a part of the initial visit).
- Line 4d: Post COVID-19 Condition (ICD-10 U09.9).
  - Column A = Number of visits at which the selected ICD-10 code for post COVID-19 condition has been coded.
  - Column B = Number of patients who have had one or more visits where post COVID-19 condition has been coded.
  - ***Note: This condition should be coded regardless of primacy. In other words, if a patient is treated for pneumonia and post COVID-19 condition, both pneumonia and post COVID-19 condition are documented in the patient health record and reflected in the corresponding lines of Table 6A.***

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Table 6A: Selected Diagnoses and Services Rendered

SELECTED TESTS/SCREENINGS/PREVENTATIVE SERVICES (LINES 21–26d):

- Use either ICD-10-CM, Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Technology (CPT) codes for each line.
- 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 (e.g., Pap test, mammogram, and family planning service) and would be reported once on each of the specified service lines.
- 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 mammography and Pap tests) are listed to capture procedures that are done by the health center but may be coded with a different CPT code for reimbursement under Title X or BCCCP. In some instances, payers and labs 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):
  - Limit the reporting of Line 21e to patients prescribed PrEP based on a patient's risk for HIV exposure AND limited to emtricitabine/tenofovir alafenamide (FTC/TAF) for the purposes of preventing HIV.
  - There are no codes to identify PrEP management, and the codes in the manual do not alone represent patient health records of PrEP prescribed to patients for the purposes of preventing HIV. Therefore, for accuracy of reporting patients on this line, it is important to limit the patients to those as noted above.

DENTAL SERVICES (LINES 27-34):

- 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 test, screening, or dental service may be provided. Report each screening, or test on each 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.

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 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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Table 6A: Selected Diagnoses and Services Rendered

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.

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				
7.	Abnormal breast findings, female	C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-, C79.81, D05-, D48.6-, D49.3, N60-, N63-, R92-	148	118
8.	Abnormal cervical findings	C53-, C79.82, D06-, R87.61-, R87.629, R87.810, R87.820	2,130	1,078
9.	Diabetes mellitus	E08- through E13-, O24- (exclude O24.41-) OID: 2.16.840.1.113883.3.464.1003.103.12.1001	30,090	9,928

CROSS TABLE CONSIDERATION EXAMPLE:

Table 6A, Line 9, Column B (see table above): Number of patients with diagnosis of diabetes in measurement year is 9,928.

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 or virtual) during the measurement year.
- Did **not** have secondary diabetes (e.g., gestational diabetes).

In other words, the number on Table 7 is smaller because Table 6A includes some patients in a different age group (younger than 18 or older than 75) and Table 6A also includes some patients with secondary diabetes, as well as some patients with diabetes that are excluded on Table 7 (e.g., patients who were in hospice care during the measurement period).

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Table 6A: Selected Diagnoses and Services Rendered

CROSS TABLE CONSIDERATION EXAMPLE: (CONTINUED)

TABLE 7 SECTION C: DIABETES: HEMOGLOBIN A1C POOR CONTROL

Line	Race and Ethnicity	Total Patients 18 through 74 Years of Age with Diabetes (3a)	Number of Records Reviewed (3b)	Patients with HbA1c >9% 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

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